

Communication between Stroke Patients and Physiotherapists

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CONTENTS: VOLUME ONE

ABSTRACT		xi
CHAPTER ONE: INTRODUCTION		1
1.1	Physiotherapy	2
1.2	The need for research into physiotherapy communication	3
1.3	Fundamental activities and central areas of communication in physiotherapy sessions	6
1.3.1	Body movement in physiotherapy	10
1.3.2	Summary	11
1.4	Aims of the thesis	13
1.5	Structure of the thesis and contents of the chapters	14
CHAPTER TWO: LITERATURE REVIEW: COMMUNICATION IN PHYSIOTHERAPY AND STROKE REHABILITATION		16
2.1	Literature on communication in physiotherapy	16
2.1.1	Distinctive aspects and beneficial effects of communication in physiotherapy	16
2.1.1.1	Criticisms and problems of physiotherapy communication	18
2.1.1.2	Notions of professional authority that underlie criticisms	21
2.1.2	Published recommendations for good communication practice in physiotherapy	22
2.2	Critical review of previous observational research into communication	25
2.2.1	A social psychology model of understanding and researching communication	26
2.2.2	Assumptions and methodological implications of the model	26
2.2.3	Criticisms of the model	29
2.2.3.1	Imposition of external variables into analyses, and assumption that shared rules govern conduct	30
2.2.3.2	<i>A priori</i> categorisation of communication conduct	31
2.2.3.3	Variables and categories are selected and measured without sufficient warrant of their significance for participants	32
2.2.3.4	Over-simplistic conception of description, and treating analysts' interpretations as superior	33
2.2.3.5	Further shortcomings of categorisation and counting	35

2.2.3.6	Limitations of the interpretations and conclusions of research using the categorising, external variables approach	37
2.2.3.7	Summary	39
2.2.4	Findings of physiotherapy communication research drawing on this approach	39
2.3	Ethnographic and other approaches to physiotherapy communication research	41
2.3.1	Critique of Thornquist's research	42
2.3.1.1	Approach to influences upon interaction conduct	42
2.3.1.2	Approach to evaluation and interpretation of conduct	43
2.3.1.3	Relationship between data and analyses	44
2.3.1.4	Relative status of observational and interview data	44
2.3.2	Relevant insights and conclusions from Thornquist's work	46
2.4	Conclusions of this critical review of previous studies of physiotherapy communication	49
2.5	Nature and effects of stroke	49
2.6	Overview of stroke rehabilitation	50
2.7	Physiotherapy for stroke	51
2.7.1	Stroke Physiotherapy Approaches	52
2.7.2	Attention to communication in stroke physiotherapy approaches	54
2.8	Features of stroke physiotherapy within inpatient rehabilitation that make it a valuable setting for studying physiotherapy communication	56
2.9	Conclusions	58
CHAPTER THREE: METHODOLOGY AND METHODS		63
3.1	Introduction	63
3.2	An introduction to how ethnomethodology and CA overcome problems of other research approaches	64
3.3	Ethnomethodology	67
3.3.1	Accountability	73
3.3.2	Context	74
3.4	Conversation analysis	76
3.5	Institutional interactions	79
3.6	Methods in CA	83
3.6.1	Data collection	83

	3.6.2	Analysis	84
	3.6.3	Transcription	88
3.7		Methods of this study	91
	3.7.1	Participants	91
	3.7.2	Selection: discussion	95
	3.7.3	Recording	96
	3.7.3.1	Advantages and disadvantages of video data	96
	3.7.3.2	Practical recording procedures in this study	101
	3.7.3.3	Additional data collection	106
	3.7.4	Analysis	106
	3.7.4.1	Labelling system for recordings	109
3.8		Role of the clinician researcher	112
 CHAPTER FOUR: ACHIEVING UNDERSTANDINGS ABOUT THE NATURE OF PHYSIOTHERAPY ACTIVITIES AND OF PARTICIPATION THEREIN			 116
4.1		Introduction	116
	4.1.1	Structure of the chapter	119
4.2		Data analysis	120
	4.2.1	Conduct in instruction-response sequences where achieving understanding appears relatively unproblematic	120
		S3Ph4PaMT1/1.41	121
		S1Ph1PaBT2/11.08	133
		S2Ph3PaHT3/11.58	144
		S1Ph2PaHT3/11.44	152
	4.2.1.1	Developing understandings in instruction- response sequences: summary	159
	4.2.1.2	Extracts illustrating patients' and therapists' orientations to therapists' authority	161
		S2Ph3PaHT3/12.03	162
		S3Ph4PaMT1/2.09	163
	4.2.2	Managing lack of understanding and misunderstandings	166
		S4Ph10PaRT3/10.24	166
4.3		Summary of interactional practices and patterns	170
4.4		Some sociological insights into patients' and healthcare professionals' conduct	172
	4.4.1	Summary	180
4.5		The collaborative nature of orientation to authority	183
4.6		Relationship between observed practices and the recommendations for practice	183

CHAPTER FIVE: ACHIEVING UNDERSTANDINGS ABOUT THE	196
SUCCESS OR FAILURE OF PATIENTS' PERFORMANCE OF	
PHYSIOTHERAPY TREATMENT ACTIVITIES	
5.1	Introduction 196
5.1.1	Structure of the chapter 198
5.2	Literature review: preference organisation, assessments 199
	and repairs in ordinary conversations and institutional contexts
5.2.1	Preference organisation 200
5.2.2	Assessments in ordinary conversation 202
5.2.3	Corrections / repairs in ordinary conversation 207
5.2.4	Assessments and repairs in institutional settings 211
5.2.5	Summary: assessments and repairs in ordinary conversation and institutional contexts 222
5.3	Data analysis: assessments of successful performance 223
	S3Ph4PaMT1/1.41 224
	S1Ph1PaBT2/11.0 226
	S1Ph2PaCT4/11.54 228
5.4	Data analysis: sequences involving assessment and 234
	management of shortcomings of performance
	S2Ph3PaHT3/11.58 235
5.4.1	Therapists' management strategies in which the problem is not named 237
	S3Ph4PaMT1/1.59 243
	S1Ph2PaCT4/11.53 244
	S2Ph3PaHT3/11.58 247
5.4.2	Importance of evaluations in contributing to patients' understanding of activities 252
	S2Ph3PaHT3/11.58 253
5.4.3	Therapists' management strategies in which the problem is verbalised 259
5.4.3.1	The therapist identifies the problem in a mitigated form 260
	S3Ph6PaOT4/11.48 261
5.4.3.2	The therapist seeks the patient's perspective prior to her talk about the problem 262
	S2Ph4PaMT1/1.56 263
5.4.4	Tying problem indications to remedies and encouragement 266
	S3Ph6PaOT4/11.48 267
	S2Ph4PaMT1/1.37 268
	S2Ph4PaMT1/1.40 269
5.4.5	Therapists' prospective management of problems through instruction format 270
	S2Ph3PaHT3/11.58 271

	S1Ph1PaBT2/11.21	272
5.5	Data analysis: patients' conduct in the face of failures of performance	274
	5.5.1 Patients' direct negative evaluations	274
	S2Ph3PaHT3/11.58	275
	S1Ph1PaBT2/11.16	275
	S1Ph1PaBT2/11.15	278
	5.5.2 Patients' apologies and perseverance	281
5.6	Summary: therapists' strategies in managing patients' problems of performance in treatment activities, and patients' responses to problems	284
5.7	Data analysis: troubles associated with soliciting assessments of performance	285
	S3Ph4PaMT1/1.41	286
	S1Ph1PaBT2/11.10	286
	S4Ph8PatQT2/10.50	287
	S3Ph4PaMT1/1.50	288
	S4Ph9PaUT1/2.55	290
5.8	Comparison between observed orientations and practices and published recommendations for good communication practice, and explanatory analysis of observed practices	296
	5.8.1 Elements of patients' conduct	301
	5.8.2 Elements of therapists' conduct	306
5.9	Conclusion	315

CHAPTER SIX: INTERACTION CONCERNING PURPOSES AND GOALS OF THERAPY	319
6.1	Introduction 319
6.1.1	Structure of the chapter 320
6.2	Clinical literature about communication on purposes and goals 321
6.2.1	Recommendations and policy 321
6.2.3	Defining goals 322
6.2.4	Advantages and difficulties of goal-setting 322
6.2.5	Findings of research into communication about purposes and goals of therapy 324
6.2.6	Clinical literature review: summary 326
6.3	Frequency of interactions about reasons, purposes and goals in the data, and related methodological considerations 327
6.4	Data analysis: interaction about reasons, purposes and rationale 329
	S2Ph2PaHT3/11.44 330
	S2Ph5PaMT1/2.13 335
	S4Ph9PaST1/10.48 343
	S1Ph2PaCT2/2.59 347
	S3Ph5PaNT2/2.25 351
6.4.1	Reasons proposed as underlying therapy and therapeutic activities 357
6.4.2	Summary: location, structure, content and interactional functions of communication about reasons and purposes 358
6.5	Data analysis: interaction about goals 363
	S1Ph1PaBT2/11.04 363
	S1Ph1PaBT2/11.00 365
	S1Ph1PaGT1/11.11 367
	S1Ph2PaFT2/1.38 376
	S1Ph1PaGT1/11.11 380
	S1Ph1PaGT1/11.22 381
6.6	Summary: interaction about reasons, purposes and goals 382
6.7	Interactional consequences and effects of talking about reasons and goals 384
6.8	Limitations of the scope of analysis within this chapter 387
6.9	Explanatory analysis of the observed patterns of conduct 388

6.10	Comparison between observed practices and the recommendations for practice	397
CHAPTER 7: DISCUSSION AND CONCLUSIONS		403
7.1	Introduction	403
7.2	Insights and implications for physiotherapy practice and research	404
7.2.1	Interactional practices during physiotherapy treatment sessions: summary of findings	404
7.2.1.1	Communication about the nature of treatment activities and participation	405
7.2.1.2	Communication about achievement of treatment activities	409
7.2.1.3	Body movement in physiotherapy communication	416
7.2.1.4	Communication about reasons, goals, and purposes underlying therapy activities	418
7.2.2	Reflection on previous findings and criticisms of communication in physiotherapy and rehabilitation	425
7.2.3	Relationship between the practices we observed and published recommendations for good practice	428
7.2.3.1	Specific practices which seem to balance the demands of recommendations and of the circumstances and constraints of physiotherapy interactions	431
7.2.4	Insights and implications for physiotherapy: discussion	436
7.2.4.1	Generation of rigorous findings about the nature and effects of interactional practices in physiotherapy	436
7.2.4.2	The generation and role of professional recommendations	437
7.3	Scope and limitations of this study and its findings	441
7.3.1	Nature and scope of findings	441
7.3.2	Limitations of this study and its methodology	442
7.4	Generalisability of findings	445
7.5	Future research directions suggested by the current study	449
7.6	Insights and implications for physiotherapy practice and research: conclusions	451
7.7	Insights and contributions to ethnomethodological and conversation analytic research and knowledge	454
7.7.1	Contributions to methodology	454

7.7.1.2	Contribution to methodology: summary	461
7.7.2	Contributions to ethnomethodological and conversation analytic knowledge	461
7.7.2.1	Body movements in clinical interactions	462
7.7.2.2	Variations in patients' interactional involvement depending on therapists' physical contribution to activities	464
7.7.2.3	Management of competence and incompetence as an influence upon conduct in clinical interactions	466
7.8	Conclusion	470
	REFERENCES	472
	ACKNOWLEDGEMENTS	487

CONTENTS: VOLUME TWO

LABELLING AND LAYOUT OF TRANSCRIPT EXTRACTS	iii
Transcript labelling	iii
Transcript layout	iii
TRANSCRIPTION SYMBOLS	vii
GLOSSARY FOR TRANSCRIPTS	x
FULL TRANSCRIPTS	
S3Ph4PaMT1/1.41	1
S1Ph1PaBT2/11.08	11
S2Ph3PaHT3/11.58	19
S2Ph3PaHT3/11.44	34
S3Ph4PaMT1/2.09	40
S4Ph10PaRT3/10.24	44
S1Ph2PaCT4/11.54	53
S1Ph1PaBT2/11.16	55
S1Ph1PaBT2/11.15	57
S4Ph9PaUT1/2.55	61
S2Ph5PaMT1/2.13	65
S4Ph9PaST1/10.48	71
S1Ph2PaCT2/2.59	73
S3Ph5PaNT2/2.25	76
S1Ph1PaBT2/11.04	88
S1Ph1PaGT1/11.11	92

ABSTRACT

This thesis reports an ethnomethodological, conversation analytic study of communication between stroke patients and physiotherapists. The study sought to describe and explicate patterns of conduct by which therapists and patients communicate about treatment activities during therapy sessions. Analysis included a comparison between practices observed in the data and current published recommendations for good practice.

The data consist of 74 treatment sessions that were video-recorded in four English hospitals. The 21 patient participants were undergoing inpatient rehabilitation for stroke. Most were recorded on four occasions over a two-week period. Their disabilities varied, but all could speak and understand at least short sentences in English. Each of the ten therapist participants was employed at senior level and used treatment approaches that are prevalent in the UK.

Analysis involved repeated viewing of data and transcription of talk and body movement. It focused on three areas that emerged as central to physiotherapy interactions:

- The nature of treatment activities and of participation in them
- Achievement (success and failure) in these activities
- Reasons, goals and purposes underlying them

Consistent with conversation analytic studies in other settings, we found that each communication practice in physiotherapy has a range of interactional

effects, and that these are locally constructed and accomplished. Therefore, rather than generating 'blanket prescriptions' about 'good' and 'bad' interactional practices, our study contributes to enhancing practitioners' understanding of the contingencies and underlying orientations that shape communication conduct, and raising their awareness of the effects of different means of achieving various interactional tasks in physiotherapy. We argue that these understandings can contribute to improvements in the practice and training of physiotherapy communication.

Our study contributes to ethnomethodological and conversation analytic knowledge regarding methodological strategies for researching lay professional interactions, and to sociological understandings about the organisation of conduct in clinical interactions, particularly the role of orientations to managing physical incompetence and its implications.

CHAPTER ONE

INTRODUCTION

This thesis reports a study of communication between stroke patients and physiotherapists. We begin this chapter by explaining the sociological and clinical relevance and importance of this study, and by providing an introduction to the nature of physiotherapy. We then present the aims of the thesis. Finally the contents of each chapter are outlined.

Research into interactions between clinicians and patients is of interest to many groups of people. These include those who participate in those interactions, as well as policy-makers and academic audiences. The latter include sociologists, who have long been interested in developing understandings about interactions within workplaces, including communication between health professionals and lay people. This study uses conversation analytic and ethnomethodological analysis of video recordings to study interactions between physiotherapists and patients in a particular setting. It reflects upon the relationship between conduct in this setting, and previous sociological analyses of clinical interactions proposed by Parsons and Goffman. It also draws upon recent analyses of workplace interactions, and of clinical and therapeutic interactions developed by conversation analytic researchers. In so doing, it seeks to describe how intersubjective understandings are achieved within physiotherapy interactions, and also explores the role played in these interactions of a number of interlinked sociological issues. These include the establishment

and maintenance of professional authority, the management of (patients') physical incompetence, and the asymmetrical distribution of interactional contributions within clinical encounters.

Besides these sociological lines of enquiry, the study explores certain clinical research topics. Since the readership of this thesis is expected to include both therapists and sociologists, we will include information about physiotherapy that may be superfluous to the requirements of clinical readers, yet is necessary to provide sociologists with an understanding of the setting studied. Thus, we will now provide a brief general introduction to physiotherapy and then a more specific description of the aspects of physiotherapy interaction that were investigated.

1.1 *Physiotherapy*

The professional body for UK physiotherapists, the Chartered Society of Physiotherapists (CSP), defines physiotherapy as:

“a health care profession concerned with human function and movement and maximising potential. It uses physical approaches to promote, maintain and restore physical, psychological and social well-being, taking account of variations in health status.” The definition goes on to note that:

“Physiotherapists are autonomous professionals, able to act as first-contact practitioners, as well as accepting referrals from other health care professionals”; that they “play a broad role in health promotion, and education and self-care” and that they “use manual therapy, therapeutic

exercise and the application of electro-physical modalities” (CSP, forthcoming).

Physiotherapy (which is also known as physical therapy, particularly in North America) exists as an occupation in many countries of the world. In the UK, physiotherapy evolved from a small group of nurses and midwives who formed The Society of Trained Masseuses in 1895, this became the Chartered Society of Physiotherapists in 1943 (Anon, 1994). In 1977, a UK Department of Health memorandum instituted professional autonomy for physiotherapists. This changed physiotherapists’ relationship with the medical profession because it authorised therapists to treat patients without prior medical referral. In 1992, the profession became all graduate in entry (Anon, 1994).

Physiotherapists in the UK work in many settings, including private practice and occupational health departments in commercial companies. However, the majority of physiotherapists are employees of the National Health Service, and work in health centres, domiciliary settings, or hospitals. These therapists work alongside other health care professionals, providing treatment for people who are receiving NHS healthcare. All the therapists involved in this study were working in NHS hospital settings.

1.2 *The need for research into physiotherapy communication*

Many commentators and researchers have noted that ‘interpersonal’ or communicative elements are integral and vital to physiotherapy (Watts, 1971;

Hough, 1987; Jensen et al., 1992; Adams et al., 1994; Sim, 1998). The major proportion of therapists' work is carried out in a context of face-to-face interaction, and its fundamental objectives are largely achieved through interaction (Dickson and Maxwell, 1985). It has been argued that physiotherapists' efforts to communicate well with patients are justified on ethical and moral grounds (Payton et al., 1998; Sim, 1998) and because of associated clinical benefits (e.g. Hough, 1987; Adams et al., 1994; Moffett and Richardson, 1997; Williams and Harrison, 1999). However, several studies and commentaries have suggested that problems and patient dissatisfaction associated with physiotherapy communication are common (e.g. Partridge, 1994; Payton et al., 1998; Stachura, 1994; Thornquist, 1994a; Williams and Harrison, 1999). Furthermore, relatively few texts and published research studies focus on physiotherapy communication, especially in comparison to those which focus on the technical elements of physiotherapy (Stachura, 1994), and upon communication in medical interactions (Payton et al., 1998).

Of the small number of previous studies into physiotherapy communication, some have adopted a categorising and counting approach, others have used qualitative methodologies, often adopting a critical stance. As we will argue in the next chapter, these approaches have considerable shortcomings, and because of this, fail to deliver constructive, practice-relevant findings. To date, there appear to be no published studies of physiotherapy that have adopted an ethnomethodological, conversation analytic approach. Studies that have applied this approach in other areas of human communication have

proved capable of capturing the complexity of communication, and generating detailed, empirically grounded findings about how and why people communicate as they do. One of the aims of this study is to demonstrate the utility of conversation analytic research in physiotherapy, and to demonstrate that the findings generated are relevant to training, practice improvement and policy generation in the area of physiotherapy communication.

Whilst the body of research literature on communication in physiotherapy is small, a substantial number of commentaries and policy documents make recommendations for good practice in physiotherapy communication (reviewed in the next chapter, Section 2.1.2). Very few of these recommendations appear to be based upon empirical research into actual practice and process in physiotherapy interactions. Instead they are underpinned by a policy-oriented stance with respect to the part that patients should play in healthcare. This is enunciated in UK Department of Health (DOH) policy documents, particularly “Patient and Public Involvement in the New NHS” (DOH, 1999), the introduction to which states that:

“Increasingly, patients want to know more about their diagnosis and about the different treatments available. They want to be able to make informed choices about their own care. This means giving patients more information, and encouraging healthcare professionals to treat patients as equal partners in the decision making process.” (pi).

This emphasis on patients being viewed, and encouraged to view themselves as “active participants rather than passive recipients of healthcare” (Williams

and Harrison, 1999, p38) has powerfully influenced recommendations for good practice. Increased attention has been paid to communication with patients in the Chartered Society of Physiotherapy's most recent "Core Standards" of practice (CSP, 2000), and a view of patients as 'partners' is emphasised (Mead, 2000).

This policy emphasis within recommendations, alongside their lack of grounding in empirical observational evidence about practice, raises questions concerning their feasibility and the relationship between the stipulations contained within them and the actual conduct of interactions between therapists and patients. A consideration of this relationship is one central element of our analysis.

1.3 Fundamental activities and central areas of communication in physiotherapy sessions¹

We will now begin to explain and justify the three areas of communication between stroke patients and physiotherapists that form the analytic topics of this study, and that emerged during analysis as central to physiotherapy interactions. Following this, we will detail the aims of the study and outline the structure of the thesis.

¹ This description derives from ethnographic data and a broad overview of the recordings collected for this thesis, augmented by the researcher's own knowledge of physiotherapy from 15 years of professional practice.

In physiotherapy, a multitude of activities is accomplished. Teaching and learning occur; bodies are moved around; explanation, advice and encouragement are given; patients and therapists exchange assessments and reports; they talk with each other, both about therapy and other matters. Sometimes there is silence; sometimes there is talk. Frequently there is physical contact between patients and therapists; at other times they do not touch each other. Like any occupational activity, physiotherapy involves specialised activities that are in many ways distinctive and particular. All these activities are conducted through interaction between individuals – patients and therapists². Therefore, as in all institutional settings (Arminen, 2000), establishing intersubjective understanding is fundamental to accomplishing the tasks of physiotherapy.

In rehabilitation of stroke patients, a primary task for the physiotherapist is to teach and facilitate the active movement control and competencies that are part and parcel of everyday physical activities. The patient's task is to work towards reacquisition of this movement control and competence. Therapists verbally instruct patients and physically move and guide their bodies, whilst patients respond to instructions and perform physical activities under guidance and inspection of the physiotherapist. A key feature of physiotherapy in this setting is its progressive nature. Over time, it tends to concern movements that are increasingly complex and demanding, or performed with increasing levels of independence from assistance.

². Interactions between therapists and caregivers, and between other healthcare workers such as assistants at times form part of physiotherapy, but are not the focus of this thesis.

A number of interactional and clinical challenges arise as a consequence of these features of physiotherapy. The participants must manage the potentially delicate situation of one adult telling another what to do. This is made more complex because the patient lacks some of the most mundane adult physical competencies (such as being able to stand up, walk, get dressed, and go to the toilet by oneself). Further difficulties arise because the movements on which therapy focuses are not usually subject to explicit conscious awareness or verbal description. Also, as in any instructional activity, problems necessitating repairs may arise when the 'student' shows difficulties of performance (Curley, 1998). Indeed because of the nature of physiotherapy treatment, and the situation of the patients (their impaired and disabled state), there is a pervasive and recurrent focus on deficiencies of physical competence, including errors in performance of treatment activities. The remedies physiotherapy offers for these deficiencies require co-operation, participation and often effortful work by patients.

Another characteristic element of physiotherapy is that, in large measure, the treatment or targeted action goes on under the eye, and indeed the hand, of the clinician. This contrasts with some of the other healthcare settings that have been subject to conversation analytic research, such as general practice consultations (Heath, 1986; ten Have, 1991; Peräkylä, 1998), specialist diagnostic clinics (Maynard, 1991a), and advice-giving sessions (Silverman, 1997; Pilnick, 1999). In those settings, patients are free to comply with or reject the advice or prescription after the consultation, without

direct monitoring by the doctor or advice-giver. In contrast, for much of physiotherapy, the therapist is present when the patient acts on the directions given. As a result, developing and displaying understanding and participation are vital for the accomplishment of physiotherapy activities, and are highly pertinent aspects of the interaction.

The first two analytic topics of this thesis concern how physiotherapists and patients interact, and develop and display understandings about the nature of treatment activities and participation in them (analysed in Chapter 4), and about the success or failure of patients' achievement of those activities (Chapter 5). The above discussion highlights the practical importance of these topics for the accomplishment of physiotherapy activities. As we will see, the importance of these areas of communication is also evident in the data themselves, in terms of the nature and the amount of attention paid to them during treatment sessions.

Our third analytic topic concerns interactions about why activities are being performed (analysed in Chapter 6). The reasons for focusing on these are somewhat different to those that underlie our focus on the first two topics. As we will show through analysis, interactions about reasons, goals and purposes are less obviously central to the accomplishment of physiotherapy tasks, and are less frequent in our data. Nevertheless, they are of analytic interest for several reasons. UK Government policy documents (e.g. DOH, 1999) and professional physiotherapy documents (e.g. CSP, 2000) place a duty on clinicians to ensure that patients understand the reasons and

purposes of treatment, and as part of this process set treatment goals with patients. Yet there is research evidence that suggests explanation and goal-setting are not done well in practice (Talvitie, 1996; Payton and Nelson, 1996), and previous research on patients' views has found that lack of explanation is an important source of dissatisfaction about physiotherapy communication (Partridge, 1994). Thus, our interest in interactions about the reasons, goals and purposes underlying therapy activities was partly stimulated by the attention paid to them in policy documents and by findings of previous studies. Also, on initial viewing of the data recorded for this study, interactional difficulties associated with this area were evident. These difficulties proved to be of analytic interest and relevance to the study's aims.

1.3.1 Body movement in physiotherapy

The role of body movement in physiotherapy differs in several respects from most other interactional situations. In most interactions, body movement occupies the background rather than the foreground of awareness and interaction (Schegloff, 1984; Kendon, 1985; Heath, 1992). It is rarely a topic of talk itself. However, body movement is a central interactional topic as well as a central interactional resource in physiotherapy.

One aspect of our analysis concerns ways in which body movements and touch form a resource for physiotherapy communication. This is especially so in the first analytic chapter (Chapter 4) where we consider ways that body movements form an important part of how therapists instruct patients in treatment activities, and a very important part of the way that patients

demonstrate their participation in these activities. We also pay considerable attention to body movements in the second analytic chapter (Chapter 5), particularly their role within the 'indirect' strategies by which failures of patients' performance are indicated and repaired.

However, for several reasons, it was decided not to make body movement and touch the central topic of analysis in the way they have been in some conversation analytic studies utilising video data (e.g. Schegloff, 1984; Heath, 1992b). One reason for this decision was the desire to develop a relatively comprehensive description of interactional patterns in physiotherapy, rather than of body movements alone. Another reason was related to the emphasis of analysis on comparing actual practice with published recommendations. The scope of the recommendations is wider than body movements alone, and so the scope of our descriptions and analysis is also wider. Also, touch presents particular problems for analysis because some of its parameters, particularly the strength or force of tactile contact, can be impossible to gauge from video recordings alone.

1.3.2 *Summary*

In summary, physiotherapy centres largely on deficiencies of patients' physical competence, and works to remedy these through actions that require patients' active, often effortful, participation and co-operation. In order to accomplish physiotherapy, mutual understanding about participation in treatment activities is required. Patients and therapists also need to develop shared understandings about how well these have been performed,

and about any corrections, if achievements and progress are to be made in treatment. Understandings about why activities are performed seem to be a significant concern to patients, and are emphasised within recommendations for good practice, which place a duty on clinicians to set goals with patients as part of building understandings about treatment. However, explanatory and goal-setting interactions seem to be problematic in practice.

The importance of these activities and concerns, evident in both the data collected for this study and in previous literature, underlies the choice of the three topics on which this thesis focuses:

1. The nature of physiotherapy treatment activities and of participation in them
2. Achievement (success and failure) in these activities
3. The reasons, goals and purposes underlying the activities

We have noted that body movement is a central topic and an important interactional resource in physiotherapy. Whilst it is not the sole focus of this study, analysis incorporates attention to it.

1.4 *Aims of the thesis*

The aims of the study, including both the sociological and clinical lines of enquiry can be summarised as follows:

1. To describe communication practices through which physiotherapy treatment activities are achieved
2. To compare actual communication conduct with that specified by professional recommendations for good practice
3. To apply a sociological perspective in order to elucidate patients' and therapists' conduct. Thus, to develop explanations for why they communicate in the ways that they do, including reasons for discrepancies between actual and recommended conduct
4. To reconsider current published recommendations for good communication practice in the light of the analysis, and to reflect on the role of recommendations with respect to guiding professional practice
5. To demonstrate that conversation analytic research can generate findings which can inform and enhance physiotherapy practice
6. To contribute to conversation analytic knowledge about the organisation of conduct during clinical interactions
7. To contribute to the development of conversation analysis derived approaches to researching lay professional interactions

1.5 *Structure of the thesis and contents of the chapters*

The next chapter contains a foundational literature review. Commentaries and critiques of physiotherapy communication are reviewed, and current published recommendations for good communication practice in physiotherapy are summarised. We will critically review the methods and findings of previous studies of physiotherapy communication. We will also outline certain issues that are specific to the setting we studied - the nature of stroke, and of rehabilitation and physiotherapy for stroke.

The following chapter (3) discusses ethnomethodology and conversation analysis and describes the study's methods, design and participants. Chapters 4, 5 and 6 report the analysis itself. Each of these chapters contains a fairly self-contained study of one particular element of interaction. Each includes a review of conversation analytic literature relevant to its topic; a thorough description of patterns of conduct observed in the data which is developed through analysis of illustrative extracts and their transcripts; and an 'explanatory analysis'. This explanatory analysis is developed by reflecting on sociological understandings of factors that shape interactants' conduct. In the final section of each analytic chapter, the relationship between the observed practices and the stipulations of published recommendations are considered in the light of these sociological understandings.

The discussion and conclusions chapter (7) includes a brief reiteration of the findings of each analytic chapter and a consideration of the scope and

limitations of the study's findings, but its main focus will be upon the broader issues raised. Bearing in mind our earlier discussion of the dual 'target audience' of this thesis, these will be divided into two areas: insights and implications for physiotherapy practice and research; and insights and contributions to ethnomethodological and conversation analytic research and knowledge.

CHAPTER TWO

LITERATURE REVIEW: COMMUNICATION IN PHYSIOTHERAPY AND STROKE REHABILITATION

In this chapter we outline commentaries, critiques and published recommendations on communication in physiotherapy, and critically review previous studies in this area and the methodologies these have employed. There will be an emphasis on literature about communication in physiotherapy and rehabilitation following stroke. Whilst some readers of this thesis will be therapists with experience in this setting, others will not. For this reason, we will also provide some 'basic' information about the nature of stroke and of rehabilitation. This will also provide an opportunity to explain features of the stroke rehabilitation setting that make it a useful and potentially productive one for studying interaction in physiotherapy.

2.1 Literature on communication in physiotherapy

2.1.1 Distinctive aspects and beneficial effects of communication in physiotherapy

In this section we will outline the benefits of good communication in physiotherapy as proposed in various commentaries and reviews. We will also summarise aspects of communication between patients and physiotherapists that have been suggested in the literature as distinctive, particularly compared to other healthcare professionals' interactions with patients. Thus, we explore what underlies Hough's (1987) claim that

physiotherapists are in a “unique position to establish effective communication with patients” (p57).

Physiotherapists often spend *longer periods in face-to-face contact with patients* than do any other members of the rehabilitation team. Also, the amount of *tactile contact* is greater than in most other professional lay relationships (Hough, 1987; Adams et al., 1994). The *communicative content and activities* of physiotherapy are distinctive, particularly in comparison to doctors' consultations. In most medical consultations there is a temporal disjunction between communicating medical advice and acting upon it (Frankel, 1993), whereas *many physiotherapy treatment activities are conducted under observation of the clinician and during the session itself*. Some authors have argued that as the *majority of physiotherapists are female*, this too has implications for communication (Hargreaves, 1987; Jones et al., 1998; Williams and Harrison, 1999).

Benefits of good communication proposed by both medical and physiotherapy research literature include:

- Reducing patients' anxiety and distress, their pain and disability, and increasing the rate and amount of recovery (Hough, 1987; Adams et al., 1994; Moffett and Richardson, 1997).
- Affecting attitudes and behaviour: increasing patients' self respect and autonomy (Hough, 1987; Williams and Harrison, 1999); and promoting patients' perception of control over their problems and ability to cope with these (Partridge, 1994; Moffett and Richardson, 1997)

- Increasing patients' adherence with treatment recommendations. This is emphasised by many writers (e.g. Wagstaff, 1982; Hough, 1987; Sluijs et al., 1993a; Partridge, 1997; Payton et al., 1998) and has been suggested as a means of achieving cost-effective care (Adams et al., 1994; Moffett and Richardson, 1997).

Conversely, inadequacies in communication are thought to lead to an increase in patients' distress (Hough, 1987) and symptomatology (Moffett and Richardson, 1997), and have been found to reduce satisfaction with care (Partridge, 1997; Payton et al., 1998).

2.1.1.1 Criticisms and problems of physiotherapy communication

We will now summarise criticisms that have been levelled at physiotherapists' communication in both general commentaries and as a result of research.

Many of these concern the purported negative effects of the 'medical emphasis' of physiotherapy.

Since its inception, physiotherapy has maintained strong links to the outlook and procedures of medicine in terms of both service organisation and conceptual base (Anon, 1994; Larkin, 1983; Roberts, 1994). A key aspect of the medical model of disease, on which physiotherapy draws heavily (Roberts, 1994), is the concept that there are normal patterns of physical activity and that deviations from these represent abnormality and a need for remediation. A fundamental concept of stroke physiotherapy is that abnormalities of movement and physical functioning must be identified and

interventions to bring these back towards normal range applied (e.g. Davies, 1985; Carr and Shepherd, 1987; Bobath, 1990; Watson, 1999). However, critics suggest that the emphasis on restoration of normal movement results in therapists' *failure to support patients' self-determination* (Williams, 1984; Stachura, 1994). Also that what has been described as therapists' mechanistic approach (Lettinga et al, 1997) leads to an *exclusive focus on patients' bodies*, or isolated parts thereof, *neglecting psychological and social aspects* of patients' experiences and complaints (Stachura, 1994; Thornquist, 1994a; Lettinga et al., 1997). Stachura (1994) claims that in neurological physiotherapy, physical, technical skills are the focus of therapists' training and aspirations, whilst less importance is placed on the "highly complex but less tangible elements of practice" (p357), and Williams and Harrison (1999) make similar criticisms of physiotherapy in general. A further criticism concerns the powerful position that therapists are said to occupy. Williams and Harrison (1999) suggest that therapists may 'perpetuate power inequalities' in a way that is detrimental, *treating patients as passive recipients of therapy*. However, they acknowledge that power is a difficult and contested concept, and that there is a lack of concrete research to substantiate these claims. The above criticisms have mainly arisen within commentaries rather than from empirical research. Those arising from observational research are closely related, suggesting that therapists sometimes *fail to give patients sufficient opportunities to express their own views* (e.g. Thornquist, 1994a; Talvitie, 1996; Jones et al., 1998) or *fail to provide them with sufficient explanation and information* (Talvitie, 1996; Sluijs et al., 1993b). Studies which have focused specifically on stroke patients'

views have often found that they report feeling they have not been given sufficient information and explanation of the processes of physiotherapy (e.g. Intercollegiate Working Party for Stroke, 2000; Partridge, 1994).

In contrast to these criticisms, some interview studies (Lewinter and Mikkelsen, 1995b; Beeston and Simons, 1996) and ethnographic investigations (Jensen et al., 1990, 1992) have claimed that therapists, particularly experienced ones, do value collaboration and empowerment of patients. These studies have also claimed that therapists attend to, and act on, the social and psychological aspects of patients' disabilities; doing so by seeking information from patients that goes beyond purely physical symptoms, and by attending to these aspects of patients' concerns in their treatment actions.

In a slightly different vein, various problems and challenges associated with physiotherapy communication have been highlighted. These include differences between professionals and patients in perspectives on disability and illness and expectations of treatment (Maclean and Pound, 2000; Hough, 1987). In stroke rehabilitation, several investigators have found a *divergence between practitioners' and patients' goals, expectations* and strategies for improvement (e.g. Kaufman, 1988b; Lewinter and Mikkelsen, 1995b).

Further problems include those presented by *impairments of patients' perceptions and communication ability*, and the difficulties and dilemmas of dealing with very *depressed or 'dependent' patients* (Lewinter and Mikkelsen, 1995b; Beeston and Simons, 1996). Although therapists report that they aim

to facilitate patients' participation and control in the management of their problems (Beeston and Simons, 1996), they also report that some patients become very reliant and dependent upon physiotherapy, making promotion of independence difficult (Adams et al., 1994; Lewinter and Mikkelsen, 1995b; Beeston and Simons, 1996).

To summarise, in interview studies, patients report communication difficulties arising because of differences between their perspectives and those of therapists, and they sometimes express dissatisfaction with the amount of information and explanation they are given. Therapists also report difficulties arising from divergent perspectives; they report difficulties dealing with patients whose communication or cognition is impaired, and with patients' dependence upon them. In commentaries and in some observational studies, physiotherapists have been criticised for imposing medically-based values of normality and independence on patients and treating them as passive recipients of therapy. They are also criticised for failing to ensure that patients are provided with sufficient information and that their views are sought and incorporated into treatments. Also for focusing on physical aspects and neglecting social and psychological elements of patients' concerns.

2.1.1.2 Notions of professional authority that underlie criticisms

In considering the arguments above, it is important to recognise that a particular view of the nature of health professionals' work and of their relationships with patients underlies many of these critiques of

communication. Professionals' main concern in encounters with patients is said to be asserting and sustaining dominance and authority over the patient (discussions and critique of this notion can be found in Maynard, 1991 and Sharrock, 1979). This view has been, and continues to be strongly held and influential in some quarters (Pilnick, 1998; Maynard, 1991b). However, a radical reassessment has resulted from development of both theory and empirical research findings (ten Have, 1991). This reassessment proposes that the asymmetry observable in patient professional encounters results from the interactional conduct of *both* parties, so that the 'dominance' of professionals is collaboratively achieved rather than imposed. Furthermore, empirical findings also show that this dominance is not so straightforward as is sometimes assumed – patients can themselves be seen to use various strategies to control and make demands upon professionals (e.g. Heath, 1997; ten Have, 1991). We further consider this reassessment Chapter 4 (Section 4.5).

2.1.2 Published recommendations for good communication practice in physiotherapy

As we have explained, a major theme of this analysis concerns how actual practice during physiotherapist patient encounters compares to recommendations. We will now detail these recommendations, to which we will refer time and again throughout the thesis.

Recommendations for good practice as articulated in policy documents and commentaries (DOH, 1999; CSP, 2000; Hough, 1987; Moffett and

Richardson, 1997) encompass general principles concerning therapists' approach, and somewhat more specific stipulations concerning communicative actions. We summarise their general themes first, then present a condensed list.

Most publications place considerable responsibility on the therapist to actively establish mutual understanding between patient and therapist through provision of information and efforts to involve patients in treatment and in treatment decisions (e.g. CSP, 2000; Association of Chartered Physiotherapists Interested in Neurology (ACPIN), 1995; Hough, 1987; Moffett and Richardson, 1997; Payton et al., 1998). Some publications have emphasised the importance of flexibility or 'improvisation' on the part of the therapist – responding to individual patients and context (Dickson and Maxwell, 1985; Jensen et al., 1992; Moffett and Richardson, 1997), and of negotiating individual goals of treatment with patients (CSP, 2000; ACPIN, 1995; Payton et al., 1998; Sim, 1998). Overall, a particular emphasis is placed on seeking and incorporating patients' understandings and preferences into the interaction and treatment process and in ensuring that patients understand and are motivated to participate in treatment.

In summary, the recommendations state that physiotherapists should involve patients in their own care by:

- Facilitating dialogue with patients (Mead 2000)
- Ensuring shared decision-making with respect to treatment processes and treatment goals (CSP, 2000; Mead, 2000)

- Actively establishing mutual understanding (Hough, 1987; Moffett and Richardson, 1997; Payton et al., 1998)

These principles require that therapists:

- Provide relevant information on clinical findings, treatment options, and the therapist's role
- Provide opportunities for patients to ask questions, and express their own views and preferences
- Check patients' understandings
- Seek and incorporate patients' understandings and preferences into the interaction and into treatment processes and goals

(CSP 2000)

Further recommendations specify that:

- Over the course of treatment, physiotherapy moves from a situation where therapists guide and direct the patient towards "a mutual participation relationship" (Moffett and Richardson, 1997, p92)
- Therapists communicate with patients in a manner that is open, honest, clear and unambiguous (CSP, 2000)
- Patient motivation is encouraged through a positive, enthusiastic communication manner (Lynch and Grisogono, 1991; Partridge, 1994)
- The general attitude toward patients should be one of respectfulness (Partridge, 1994), with patients treated as equals and experts in their own right (Mead 2000), not as children or idiots (Partridge, 1994)
- Dependence of the patient on the therapist is avoided. Instead, they are to be enabled and encouraged to take control and responsibility

for their recovery and actions (Moffett, 2000; Partridge and Johnston, 1989)

Most of these recommendations do not derive from specific research projects, except for those referenced to Partridge (1994): a small focus group interview study; Partridge and Johnson (1989): a small questionnaire study; and Payton et al. (1998): a larger interview study. Thus only a small proportion of recommendations have a base in research studies, and none of these studies involved direct observations of practice. Nevertheless, a body of research studies that have involved direct observation of physiotherapist patient interactions exist. The following section includes a consideration of these.

2.2 Critical review of previous observational research into physiotherapy communication

Most research into physiotherapy communication has adopted methods developed from theory and studies in the field of social psychology. In the following review we will describe the model of human communication that is involved, and the methods that follow from it, illustrating with some social psychology and physiotherapy studies. We will argue that these methods have considerable limitations, and that as a result, this research approach fails to adequately encompass various aspects of human communication, so that findings and recommendations lack both rigour and (practical) detail. A small number of physiotherapy studies have drawn upon alternative traditions such as ethnography, these will be considered in a later section.

2.2.1 A social psychology model of understanding and researching communication

The following discussion draws on descriptions by Argyle (1988) and Bull and Roger (1988). Argyle presents a 'basic paradigm' of communication between two participants, A and B, wherein A encodes a 'message' that B decodes, using a shared code. Encoding and decoding may proceed unproblematically, with A and B understanding each other and intending this to be the case. Alternatively, misunderstandings may result from erroneous sending or receiving of messages, or deceptive sending of messages.

2.2.2 Assumptions and methodological implications of the model

This paradigm and the related research recommendations entail certain conceptual assumptions. Words and non-verbal elements of communication are viewed as having definite meanings which people succeed or fail to learn and accurately apply. This leads to a model wherein competence in 'social skills' is seen in terms of correct learning and application of meanings and rules. In 'special' settings such as medical consultations, different rules are considered to come into play, such as those concerning tactile contact. These different rules are envisaged as understood and conformed to by participants, and the model does not explore *how* they come to be established and understood.

Besides the idea that people act according to shared, internalised rules, a further element of the model is the assumption that pre-existing factors, which are external to the individual context and immediate situation, govern or at least systematically affect communication. This leads to a research methodology in which external variables (including participants' attributes such as gender, and aspects of setting) are identified, measured and sometimes controlled for in a laboratory setting, or are controlled by comparison across different settings (Roger and Bull, 1988; Zimmerman and Boden, 1991). In some studies, variables include subjective, 'internal' factors such as attitudes. These are treated as stable and independent of the circumstances of individual interactions. Like rules, variables are treated as consistently influencing every interaction.

Comparisons across different settings and controlled variables proceed by quantifying aspects of communication, then making and comparing frequency counts. Thus, a further element of the research methods in this approach is that aspects of communication are classified into independent and discrete categories. These category systems are applied to observed or recorded interactions, and frequency counts are computed. Frequencies may be compared across settings or participants, and/or statistical associations between various external variables and communication categories calculated. Such statistical analysis is said to enable the researcher to arrive at an objective decision about the importance of a particular aspect of behaviour or variable (Bull and Roger, 1988).

The majority of physiotherapy studies of communication seem to have followed this model, using a system of categories to measure communication (Dockrell, 1988; Jensen et al., 1990, 1992; Sluijs et al., 1993a, b; Adams et al., 1994; Jones et al., 1998). The category system is applied during observation (Dockrell, 1988; Jensen et al., 1990, 1992; Jones et al., 1998) or to recordings (Sluijs et al., 1993a, b; Adams et al., 1994) and frequency counts are made. Frequency distributions are compared across different settings (e.g. Adams et al., 1994), or different participant characteristics, e.g. experience of staff (e.g. Jensen et al., 1990).

A further element of the model is that communication by participants 'A' and 'B' is treated as separate, and indeed they are often investigated separately in terms of 'encoding' (message-sending) and 'decoding' (message-receiving) research. Correspondingly, physiotherapy studies in this tradition generally set out to investigate only physiotherapists' ('encoding') conduct. This analytical separation also extends to different 'channels' of communication such as talk, gaze, gesture, and touch (Argyle, 1988), which are treated separately in data collection and analysis. Hence, some of the physiotherapy studies consider only verbal behaviour (Sluijs et al., 1993a, b), and those that have included non-verbal elements treat them as a separate set of categories (Adams et al., 1994; Jones et al., 1998).

In research based upon this model, choices about which external variables and which communication behaviours are measured and incorporated into research designs and explanatory models tend to be treated as

straightforward and self-evident (Hopper, 1988). The assumptions and considerations that led to these choices are often neither considered nor articulated by researchers. When warrant is offered for choices, few studies attempt to ground this in data (Jensen's studies are exceptions). Instead, warrant is made by reference to common-sense ('what everyone knows') and by recourse to research and theoretical literature. Physiotherapy research by Jones et al. (1998), who studied final year physiotherapy students' communication skills, illustrates this. The researchers observed English-speaking Australian students treating English-speaking patients, and Hong Kong Cantonese-speaking students and patients. Frequencies of various behaviour categories were compared between the different nationalities, also between different genders of patients and therapists. Categories included 'explanation/instruction', 'silent period', 'verbal reinforcement', 'eye contact', 'facial expression', information finding', and 'response with interest'. The researchers' clinical knowledge is used to justify their choice of communication skills categories: these "were seen by the authors, each of whom is an experienced clinician, to be important to the quality of physiotherapy" (p182).

2.2.3 Criticisms of the model

The traditional quantifying approach has been described as a clear and economical way of presenting and accounting for a complex database, and providing objective and generalisable findings (Bull and Roger, 1988). Others, particularly those drawing on an ethnomethodological perspective, argue that its descriptions and explanations simplify and reduce the

complexity of human communication to a degree that precludes satisfactory and coherent analysis (Heritage, 1988a; Hopper, 1988). From the same perspective, it is argued that in both the selection of variables and categories of conduct, and the sorts of interpretations that are made, the knowledge and views of the analyst are (inappropriately) privileged and treated as superior to those of the people they are studying (Heritage, 1984; Silverman, 1997; Schegloff, 1997). We will discuss the ethnomethodological approach in detail in the next chapter. For now, we will illustrate in more concrete terms the shortcomings of the social psychology model. These concern the coherence of analyses, adequacy of descriptions, and the warrantability of findings and conclusions.

2.2.3.1 Imposition of external variables into analyses, and assumption that shared rules govern conduct

As we have noted, the research approach we have been examining assumes that pre-existing variables and rules, which are independent of the local interactional circumstances, shape, control and explain individual events within interactions. Part of the assumption that interactional conduct is rule-governed is the view that that people 'know' the rules of communication and apply them in individual situations. For instance, Argyle's (1988) suggests that: "There appear to be definite rules which permit certain kinds of touch, between certain people, on certain occasions only" (p224-5), claiming that in medical consultations, "a specialised kind of touch is used, with no great implication of intimacy" (p225). However, this form of claim fails to consider how people come to know how to deal with and share understandings of

conduct in such situations. Furthermore, such claims are not borne out by empirical research. For instance, research into gynaecological examinations (Emerson, 1973) has shown that issues of sexual delicacy cause interactional difficulties which are dealt with in complex and methodical ways by both examiner and examinee and that *the implication of intimacy is treated as ever-present* by participants. It seems that what underlies conduct is more complex than a set of regulations and variables.

2.2.3.2 *A priori* categorisation of communication conduct

Categorisation rests on an assumption that a single correct description of the given behaviour is possible. However, empirical research shows communicative actions do more than one thing at once (e.g. Goodwin, 1979), and furthermore, that they are not so static as the model assumes. Empirical findings indicate that the meaning and description of an action may be reviewed over time and may differ amongst different participants (Potter and Wetherell, 1987). Mutually exclusive, pre-formed categories cannot but ignore these essential characteristics of communication. Imposing a categorisation framework can thus lead analysts to miss features of what is occurring in and significant for the interaction, distorting and reducing descriptions and explanations. Also, to reiterate an earlier argument, categorisation entails imposition of the analyst's view of which elements of communication are important within the interaction, at the expense of detailed investigation of which elements participants themselves treat as important.

To illustrate the shortcomings of categorisation, we again turn to Argyle (1988), who claims that the meaning of certain gestures is shared and understood by all members within a culture or cultural group. He gives the example of the 'hitch-hike' sign, and proposes this a single meaning that can be described briefly and completely. However, this gesture might be used in many different ways: in a practical manner to hitch a lift, or ironically, or humorously, or even as part of a dance. Its meaning(s) at that time and in that context be understood by examination of the local context, but not by simplistically placing it under one category. For a more physiotherapy-specific example, let us imagine a therapist placing her hand on a patient's shoulder. This 'simple' action may serve many functions simultaneously, for instance: adjusting posture, providing reassurance to the patient, and sensory information about the patient's muscles to the therapist. To categorise it simply as, for instance 'non-medical touch', as might the physiotherapy studies discussed (e.g. Adams et al., 1994), is at best superficial and at worst a distorted description. Touch, as with all other communicative actions, may do several things at once and be oriented to by participants themselves as such. Yet the measurement systems used require each action to be defined as one thing and one thing only, and always the same thing on each occasion.

2.2.3.3 Variables and categories are selected and measured without sufficient warrant of their significance for participants

Investigators using the model we have been describing are also criticised for failing to provide adequate justification for their choice of which external

variables and which categories of communication are measured, and how these are measured. As we noted, in several physiotherapy studies, choices are informed by the research literature, by personal experiences, or clinical expertise; they are commonly left untested and unjustified in terms of empirical data. That is, studies often neglect investigation and demonstration of what participants treat as important and relevant.

A further problem for any categorisation system which relies on clinicians, even expert ones, is that much of what occurs within interactions goes unnoticed and unreported (Miller, 1997). The complexity of interactional conduct even over short stretches of time has been demonstrated by numerous empirical studies (e.g. Heath, 1986, 1997; Goodwin, 1979). Thus, members' accounts of conduct can only generalise and gloss these processes.

2.2.3.4 Over-simplistic conception of description, and treating analysts' interpretations as superior

Defining and measuring external variables and behaviour categories entails a view in which description is seen as capable of directly reflecting external reality given appropriate application of measurement procedures. While this view of description and measurement may be sufficient for some purposes, our argument here is that it does not allow adequate investigation and understanding of communication. Hence, much of the criticism of this model rests on theoretical insights and empirical research concerning the nature of descriptions. In this alternative view, description can never be definitive and

complete. All descriptions must involve selection, employment of certain perspectives, and interpretation. Also, Potter and Wetherell (1987) point out that: "talk is not just 'about' actions and events but is also a potent working part of these things" (p72). That is, the act of describing is itself part of the construction of social action and meanings: so description cannot offer independent commentary (Heritage, 1984). An illustration of the complexities of describing communication conduct can be drawn from the conclusions of Jones et al. (1998) who, it will be recalled, correlated frequencies of physiotherapy students' communication behaviours with gender and ethnicity of patients and students. Compared to English-speaking Australian students treating English-speaking patients, Hong Kong Cantonese students treating Cantonese-speaking patients scored significantly lower on all communication categories except for percentage of treatment that was silent. The authors state that, compared to Hong Kong students, Australian students "were deemed to be more aware of their patients as people and of the need to respond to them" (p184). This provides a clear illustration of how the process of description necessarily entails interpretation, and a construction of the meaning of conduct and 'what is the case'. As the authors acknowledge, their observations of communication behaviour utilised a 'Western model' which implicitly assumes that certain behaviours (universally) constitute skilled and effective communication. That is, their categories describe communication from a particular perspective. Their implication that Hong Kong students are less aware of their patients as people entails interpretation and construction. Thus, alternative descriptions and constructions of 'what is the case' are always possible: the researchers might have described the

greater silence and lower frequency of questioning patients as an indication that Cantonese students showed a proper respect towards patients. Notably, this form of interpretation and description rests on an assumption on the part of the analysts that only they grasp what is 'really' going on, and that their selection of what is important and how it is to be interpreted has privileged status. Schegloff has argued that such an approach entails "theoretical imperialism" wherein analysts stipulate the terms of reference by which the world is to be understood (Schegloff, 1997, p167). It also relates to what Silverman (1997, Chapter 2) describes as 'the Divine Orthodoxy', which holds that only social scientists can see through people's claims and activities, so as to grasp what is 'really' going on.

2.2.3.5 Further shortcomings of categorisation and counting

A further assumption of this approach is that the frequency of a behaviour equates to some aspect of its quality. This can be seen in a number of physiotherapy communication studies, for instance Sluijs et al.'s study (1993b). This large study focused on physiotherapy communication in the Netherlands. Observations of 'patient education activity', and amount of 'counselling' during 1837 audio-recorded treatment sessions were correlated with the 84 therapists' self-reported attitudes towards patient education. Trained observers applied a checklist of categories to the recordings. These purported to measure the type, quantity and quality of patient education occurring. To illustrate our argument, we consider one category: 'therapists' awareness of patients' demands', which was measured as the number of times the therapist asked the patient to express demands, opinions and

desires. Yet a therapist could conceivably ask many such questions but not attend to any of the patient's responses. Another therapist might produce only one such question, but devote much of the session to attending to and addressing the patient's response. That is, therapists' interest in patients' concerns may have less to do with the frequency with which the patient is asked about them, and more to do with whether the therapist attends to and addresses these concerns (*c.f.* Schegloff, 1993, Section iv). Simplistic coding and counting, and separate treatment of patients' and therapists' conduct cannot adequately address such issues.

Besides the problem of lack of meaning of frequency counts, there are further problems in Sluijs et al.'s (1993b) categories. Ten Have's (1991) consideration of patients' questions during medical consultations is relevant here. He used empirical evidence to show that patients "have a variety of ways in which they make known to their physician their informational needs" (p147-8). He thus shows that the common-sense category 'question' fails to encompass the subtlety of communication conduct. Therapists in Sluijs et al.'s study may have elicited patient's demands, views and desires through other means than direct questions, but it seems their category system could not take this into account. Ten Have's analysis illustrates the problems inherent in categorising behaviours in seemingly transparent and common-sense ways.

2.2.3.6 Limitations of the interpretations and conclusions of research using the categorising, external variables approach

Besides the *methods* of this approach, the *findings* of studies utilising it are also open to criticism, particularly in terms of their explanatory power and descriptive depth. For an example, we turn again to Jones et al.'s study (1998). As noted above, the study hypothesised that therapists' and patients' culture and gender were systematically associated with communication behaviours of student therapists. Statistically significant differences between Hong Kong Cantonese and Australian English-speaking students were found, including a significantly lower score for Cantonese students on all communication categories except 'percentage of silence'. This begs the question: Is it simply that they did not perform the categorised behaviours, or did they do other things instead? The external variables model cannot answer this question nor provide any detailed analysis of *how* Australian and Cantonese students differed. The local production of meaning, and how and why this might differ between participants is left unexplored.

Another example illustrating shortcomings in terms of both explanatory power and descriptive depth are Jensen et al's (1990, 1992) studies. They found that more experienced therapists' communication with patients was 'flexible, dynamic, intense, and integrated'. However findings fall short of the depth of detail which would be needed were practitioners wishing to act upon them.

Besides the conceptual of the model, and its failure to deliver practice-relevant findings, it seems to lack explanatory power even on its own terms.

For instance, in the study by Sluijs et al. (1993b), a statistical model explaining variations between the therapists' behaviour in educating their patients and their self-reported attitudes towards patient education was sought. Many variables were entered into the statistical model. Yet sixty percent of the variation between therapists' behaviour remained unexplained. They also report that quality of patient-therapist relationships across the 1837 sessions 'varied little'. This seems highly unlikely. It might be more accurate to say that the measurement tool used was not sufficiently sensitive to discern differences.

Concerns with validity also extend to some of the clinical, 'common-sense' assumptions that inform interpretation of findings. Jensen et al. (1992) assume that the greater proportion of physical contact noted amongst 'master' as opposed to novice clinicians is a positive feature of their interactions. However other clinical experts (e.g. Carr and Shepherd, 1987) argue that therapists should 'keep their hands off' patients as far as possible so as to encourage relearning of independent movement. Likewise Sluijs et al. (1993b) count 'attention to pain' amongst the positive indicators of therapist patient relationship. On the other hand, Moffett and Richardson (1997) suggest that too much attention to patients' pain encourages 'pathological pain behaviour'. Neither Jensen nor Sluijs pay close attention to the interactional effects and trajectories that are associated with increased tactile contact, or attention to pain. These studies therefore lack the power to resolve questions about the effects of different patterns of conduct.

2.2.3.7 Summary

We have argued that it is mistaken and over-simplistic to view conduct as shaped and governed by aspects of external context and participants' attributes. Also that the associated tendency in research that adopts this view for researchers to impose their own interpretations, whilst leaving these unexplored in terms of empirical data is problematic. As a result, research using this approach fails to attend carefully to the practices, orientations and perspectives of the people studied, and a lack of explanatory power and depth of findings. In treating 'encoding' and 'decoding' as distinct and separate processes and research topics, and separating different 'channels' of communication, this type of research fails to address essential features of human communication, these being its multifaceted, but methodical and collaborative production and understanding.

2.2.4 *Findings of physiotherapy communication research drawing on this approach*

Most of the studies discussed so far have rather limited relevance to the current study, because of both the type of findings, e.g. correlations between communication and various external variables. Also because of their topics: several studies concern student therapists' communication (e.g. Jones et al., 1998; Dickson and Maxwell, 1985) and most focused solely upon therapists' communication (e.g. Adams et al., 1994; Sluijs et al., 1993a, b; Jones et al., 1998). Nevertheless, some findings are of relevance. Some of these pertain to topics which we will consider within specific analytic chapters. Two more general areas of findings are worth mentioning here.

Unsurprisingly, variations have been found in communication conduct across different clinical settings, across therapists' and patients' gender and culture, and between individual therapists (e.g. Adams et al., 1994; Jones et al., 1998; Sluijs et al., 1993a, b). This variability has led researchers to call for improved 'social skills' training for physiotherapists (e.g. Dockrell, 1988; Sluijs et al., 1993a, b; Jones et al., 1998).

Another relevant area of findings concern Jensen et al's (1990, 1992) studies of communication by experienced and less experienced therapists (mentioned above in Section 2.2.3.6). The categories by which Jensen et al. investigated communication during treatments were derived from systematic analyses of field-notes and audio-recordings of clinical treatments (1990), and both therapists' and patients' communication were considered. In the later study (1992), these categories were applied to observations and audio-recordings of treatments by 'master' and novice clinicians in orthopaedic settings using a case-study approach. Master clinicians were reported to have greater ability to control the clinical environment, handling and controlling interruptions 'smoothly'. They were able to maintain intense, focused verbal and non-verbal communication with patients. They showed "dynamic elicitation and use of data tailored to the patient" (p718) deviating from standard assessment frameworks to probe deeper and 'listen intently' (p715). This contrasted with less experienced therapists who tended to focus purely on eliciting information from patients which could validate or invalidate diagnoses. These findings concur with those of Dockrell (1988) who noted

that the student therapists she observed seemed “intent on perfecting treatment techniques” (p55) and keeping accurate records, and as a result sometimes failed to respond to patients’ utterances and non-verbal ‘signals’. We argued above that Jensen’s findings lack the detail required for application to actual practice. The current study aims to provide more detailed descriptions and explications of therapists’ skilled practices.

2.3 *Ethnographic and other approaches to physiotherapy communication research*

Alternative methodologies to the prevailing social psychology approach exist, and some of these have been applied to physiotherapy. Some of the research reviewed above has ethnographic elements (Jensen et al., 1990, 1992), and other ethnographies have been conducted. However, most have concerned subject matter fairly remote from patient therapist interactions: Scully and Shepard (1983) and Jensen (1988) examine aspects of the delivery of physiotherapy training, and Smith (1996) focuses on the working culture of physiotherapy assistants. Davis and Strong (1976) did consider patient therapist interactions, but their focus is on interactions with children, and so is also of limited relevance here. Of more relevance are several papers published by a Norwegian physiotherapist and researcher, Thornquist (1994a,b, 1995, 1997) who used ethnographic methods to study physiotherapy sessions. Although limited in its influence³, we will consider

³. Currently, the most influential literature pertaining to physiotherapy communication seems to be interview studies (e.g. Gyllensten et al., 1999), and commentaries and recommendations

Thornquist's work here because her subject matter is fairly closely related to that of this thesis, and because she used observation of video-recordings as a method of analysis. Thornquist (1997) explicitly rejects the 'code and count' model of research, and the sender/receiver model of communication, however, her analytical approach differs considerably from the position that will be taken in this study. The form of interpretation, reliance on *a priori* assumptions, and imputation of motives and meaning entailed in her analyses contrast with the methodological restrictions that ethnomethodological and conversation analytic approaches place on analyses. The four papers by Thornquist that we discuss here all derive from the same dataset, which comprised video-recorded, observational, and interview data pertaining to first-time encounters between physiotherapists and patients. Five 'manual' physiotherapists', five 'psychomotor' physiotherapists and five domiciliary physiotherapists were each recorded once. One paper (1994b) compares the groups of therapists; the others are case studies focusing on each group individually.

2.3.1 Critique of Thornquist's research

2.3.1.1 Approach to influences upon interaction conduct

Although Thornquist suggests that encounters are "coconstructed by the participants", she also argues that they are "'preformed" by situational and institutional demands and circumstances" (1997, p347). As a consequence,

only loosely based on empirical research (Moffett, 2000; Williams and Harrison, 1999) or on small-scale focus group interviews (CSP, 2000).

the influence of certain factors on the participants' conduct is assumed rather than induced from analysis of data. For instance, in the case study of manual physiotherapists specialising in treating patients with orthopaedic problems (1994a), Thornquist seems implicitly to assume, rather than to uncover through data, that the content and direction of physiotherapy encounters is largely supplied externally by therapists' 'biomedical reductionist' perspective and professional power. Thus, like the 'external variables' approach, this analysis involves invoking "a realm of variables ... to explain the specific character of practical activity within some particular occasion" (Heath, 1997, p186). It assumes that *a priori* factors 'govern' conduct. As a result, attention is deflected away from the inherent details of the data.

2.3.1.2 Approach to evaluation and interpretation of conduct

In general, Thornquist takes an explicitly evaluative, indeed critical stance concerning the therapists' clinical competence (see below). Also, she imputes motives, attitudes and intentions to participants. For instance the extracts in the domiciliary case study (1997) include talk by the patient's wife, who is described at one point as 'not leaving well enough alone' and her talk as 'condescending'. That is, the analyst makes judgements and evaluations about what is 'really' going on, what people are 'really' thinking and meaning. A particular problem with this sort of approach is that it is difficult to warrant the validity of that particular interpretation as opposed to any other, especially as the connection between the proposed meanings and the details of conduct in the actual data are frequently glossed over. In Thornquist's work,

as in other studies of rehabilitation (see Section 2.6), there is a tendency for the analyst to be judgmental and condemnatory, particularly of professionals' practice. For instance, in one study (1994a), she argues that in certain respects the therapists she studied "can hardly be said to have displayed clinical competence" (p708). Such critical approaches are arguably counterproductive, and rarely constructive in providing clear or concrete guidance to professionals as to how interaction could be changed and improved.

2.3.1.3 Relationship between data and analyses

We have already suggested that Thornquist's analyses make considerable interpretive 'jumps' from data to claims about therapists' conduct and in particular, to claims about their guiding orientations. Further criticisms of the relations between the data and the claims she makes can be suggested. From an analysis of one or two encounters in the case studies (1994a, 1995, 1997), substantial inferences are made about the reasoning and thinking underlying physiotherapists' conduct in general. Although it is implied that the cases described illustrate features "not uncommon" throughout the database (1994a, p701), no other reference to this larger body of data is made. Thus, although claims are presented as generally relevant, warrant for such generalisability is lacking.

2.3.1.4 Relative status of observational and interview data

Thornquist conducted interviews with the therapists following the video-recorded patient assessments. She explains that in interviews, she aimed to

get at the intentions, reasoning, and ways of thinking that motivated their conduct (1994a, 1995). She states that: "One general problem regarding observation is that one cannot know what the parties involved think, perceive or intend to do. One has to draw conclusions from their actions ... In the interview following the encounter, I therefore intentionally tried to find out the therapist's intentions and reasons for his practices" (1995, p190).

The underlying notion that interviewees provide unproblematic reports of events and directly reveal social meanings is problematic on several counts (Heritage, 1984; Murphy et al., 1998). It relies on 'meaning equivalence' - that the utterances of respondents and interviewer refer to the same things and are mutually understood. It also neglects the way that selective processes inevitably influence collection and analysis of interview accounts - an interviewer must select her questions and choose which responses to treat as relevant. Perhaps even more importantly, it is well recognised that reports only 'loosely' fit the circumstances they depict (Heritage, 1984). Traditional approaches frequently explain this 'looseness' as arising from interviewees' shortcomings, for instance 'lying' or 'forgetting'. An alternative view is that verbal accounts and reports are situated and contingent (Murphy et al., 1998) and hence that interviews cannot constitute some form of external and independent commentary on events. Accounts and reports perform actions such as defending, justifying and explaining conduct, and for this reason the relationship between what people say, what they do, and

what they believe is an indirect one⁴. Furthermore, practitioners' statements "routinely gloss over or conceal the practical world" involved in accomplishing occupational goals (Heritage, 1987, p262). Thus, therapists' and patients' accounts cannot then be expected to provide comprehensive reports about their complex practices during physiotherapy.

2.3.2 *Relevant insights and conclusions from Thornquist's work*

We have argued that Thornquist's *a priori* assumptions and evaluative position lead to interpretations that are insufficiently substantiated by careful examination of the endogenous orientations of physiotherapists and patients. Therefore these analyses and findings should be treated with caution. However, in comparison to most other research into physiotherapy communication, Thornquist's analyses are very detailed, and informed by wider theoretical influences. Also, although her empirical data do not appear to have been analysed at the systematic level of detail typical in conversation analytic studies, efforts are made to consider the relationship of bodily conduct and talk, and to consider patients' part in the collaborative production of the interactions. Therefore aspects of her findings have relevance to the current study.

⁴. These criticisms of the status of accounts and self-reports also apply to self-completed questionnaire responses of the sort used by Sluijs et al. (1993 a, b) to measure therapists' attitudes.

The comparative analysis between therapists working in different settings (1994b) found marked divergence in terms of content, manner of communication and therapeutic strategies adopted by therapists following the different therapeutic approaches. This echoes findings of other observational studies of physiotherapy communication (Section 2.2.4). The implication for this current study is that we must appreciate that even where recurrent and pervasive patterns of conduct are found, these might be particular to the circumstances of the setting, therapists, and patients involved, and that variations in other settings are likely. There will therefore be an emphasis on reasoned argument to support any claims concerning features proposed as generic to physiotherapy interactions, and an awareness that future research would need to verify such claims (see Chapter 7, Section 7.4).

In the study which considered therapists assessing patients with musculoskeletal problems (1994a), and to a lesser degree the study of a home visit to a stroke patient and his wife (1997), Thornquist claims that therapists operate and communicate with two separate and 'unintegrated worlds of knowledge': the therapeutic, technical and physical; and the subjective and personal. She argued that therapists examined and talked about the body and person "as mutually non-related, while therapists in their general communication unknowingly relate to their patients as embodied subjects." (1994a, p711). Thus she asserts that therapists fail to attend sufficiently, and in a sufficiently integrated manner, to the social and psychological elements of patient's concerns about their condition. Furthermore, echoing other critics of physiotherapy discussed above, she

argues that therapists prevented patients from presenting their own version of their complaints.

A main focus of the analysis of a home visit to a stroke patient and his wife (1997) concerned the effect of the wife's presence on the pattern of interaction, which is not highly relevant to the current study which concentrates on one-to-one patient therapist interactions. However, Thornquist also describes how the physiotherapist controlled the sequence and structure of the encounter. With a somewhat different view to her earlier studies, she argues that this did not represent 'domination', but 'professional control' - "an essential organising feature of encounters in order to get the job done" (p347). She also argues that when interaction is analysed, clinical tasks can be seen to be "embedded in social processes" (p348). Both these arguments seem more aligned to an ethnomethodological perspective than those underlying her earlier analyses, and seem to indicate an alternative view to that which proposed therapists separate clinical and social elements of communication.

In the current study we will take a close and detailed look at the different levels and forms of participation and interactional contributions by therapists and patients, and will consider whether the patterns described by Thornquist and others are apparent in our data.

2.4 *Conclusions of this critical review of previous studies of physiotherapy communication*

If communication is to be better understood, and practice-relevant findings generated, this needs a methodology that can capture the complex, multifaceted, collaborative, local production of interaction, and can explore it in the terms of the participants themselves rather than imposing interpretation and judgement from outside or 'above'. The approaches of ethnomethodology and conversation analysis (hereafter, CA) offer just such an alternative, and will be described in the next chapter. However, before this, we will spend a short time describing the nature of stroke and rehabilitation, and summarising guidance on communication that has been contained within stroke physiotherapy texts.

2.5 *Nature and effects of stroke*

A stroke is a neurological deficit of sudden onset caused by disturbance of blood supply to a section of the brain. It results in loss of function of that part of the brain resulting in death or varying degrees of disability (DOH, 2001; Effective Health Care, 1992). Stroke is the commonest cause of adult disability in Britain, with a "substantial proportion of health and social care resources ... devoted to the immediate and continuing care of people who have had a stroke" (DOH, 2001, p61).

Disabilities caused by stroke result from loss or impairment of use of limbs (usually on one side of the body), disturbances in balance ability, visual difficulties, speech difficulties, and/or decline in cognitive functions (Bamford,

1991; Effective Health Care, 1992). Patients describe a perceived loss of bodily control and integration of body and self. The body feels “unwilling” (Brodal, 1973) and movement becomes highly effortful rather than automatic (Brodal, 1973; Doolittle, 1992; Jongbloed, 1994). Personality, social relationships and participation, and sense of self are all frequently altered by stroke (Kaufman, 1988a; Jongbloed, 1994; Cox et al., 1998).

2.6 Overview of stroke rehabilitation

There is strong evidence of better survival and recovery of function in stroke patients who have been admitted to a hospital-based stroke unit, and treated by a co-ordinated team of professionals including rehabilitation therapists, and (UK) National Health Service policy stipulates that stroke should be managed in this way (Intercollegiate Working Party for Stroke, 2000). There are many definitions and descriptions of stroke rehabilitation (e.g. World Health Organisation, 1989; Effective Health Care, 1992; Wade, 1994). Wade’s (1994) comprehensive summary proposes that rehabilitation is a problem-solving, educational process that aims to minimise the patient’s handicap and distress, and to minimise the stress and distress suffered by the patient’s intimates. He notes that these efforts to minimise impact are constrained by the limits of the patient’s pathology and their environment. Rehabilitation includes both physical and psychological therapies and support, and the need for patient (and carer) involvement in the process is often emphasised.

There have been several sociological studies of stroke rehabilitation (e.g. Pound et al, 1994a, Gold, 1983; Kaufman and Becker, 1986; Kaufman, 1988a; Jongbloed, 1994) many of which express criticisms of how it is conducted. These are similar to the criticisms that have been levelled at physiotherapists, suggesting that rehabilitation is dominated by a 'medical emphasis' on physical rather than social and psychological aspects of patients' problems (Hill, 1978; Forster and Young, 1992; Pound et al, 1994b). It has been argued that this emphasis results in a large number of patients failing to return to anything near their pre-stroke levels of social participation and lifestyle, even for those who make a good physical recovery (Forster and Young, 1992; Lewinter and Mikkelsen, 1995a; Tyson, 1995). This medical emphasis has been said to constrain patients' active involvement in rehabilitation (Hill, 1978; Venesy, 1994). Part of the medical emphasis is said to entail an assumption that the primary and over-arching goal of rehabilitation should be functional independence, i.e. the ability to carry out the various physical tasks of daily life without assistance. Critics assert that this goal is often imposed upon patients, rather than wished for by them (Gold, 1983; Kaufman and Becker, 1986; Kaufman, 1988a; Jongbloed, 1994).

2.7 *Physiotherapy for stroke*

Physiotherapy is widely recognised as a major component of formal stroke rehabilitation services (World Health Organisation, 1989; Effective Health Care, 1992; Ashburn et al., 1993; Wade, 1994), and treatment of stroke patients is a sizeable physiotherapy specialism (Ashburn et al., 1993; Lennon, 1996). The recent national 'Clinical Guidelines for Stroke' published

by the Royal College of Physicians, state that physiotherapists “should co-ordinate therapy to improve movement performance of patients with stroke” (Intercollegiate Working Party for Stroke, 2000, p50).

The ultimate goal of stroke physiotherapy has been described as “the reduction of the physical contributions to the patient’s disability” (Duncan, 1994, p404). Its particular concern is with patients’ motor control and their musculoskeletal system (Ashburn et al., 1993; Beeston and Simons, 1996; Watson, 1999). The process of stroke physiotherapy includes identifying deviations from normal movement and posture, and applying various therapeutic strategies aiming to reduce such deviations. These strategies include physical guidance of patients’ movements, verbal instruction and education of carers, goal-setting, and general emotional support (Effective Health Care, 1992; Beeston and Simons, 1996).

2.7.1 Stroke Physiotherapy Approaches

A variety of distinct approaches to physiotherapy treatment for stroke patients exist (Rudd and Robinson, 1996). Most aim at restoration of movement towards normality, but each employs different strategies to achieve this. The most prevalent British approach is called the ‘Bobath’ or neurofacilitatory approach (Lennon, 1996; Sackley and Lincoln, 1996), which emphasises the restoration of normal patterns of movement, and therapists’ skilled physical manipulations and guidance of the patient (Davies, 1985; Bobath, 1990; Lennon, 1996).

An alternative approach which also has some influence on current British practice (Lennon, 1996; Sackley and Lincoln, 1996) is the 'movement-science' approach (Carr and Shepherd, 1987, 1990). This approach claims to be based on theoretical and scientific principles deriving from experimental research findings (Shepherd and Carr, 1994). As in Bobath, the analysis and correction of deviations from normal movement are central. However, manual guidance or handling is generally discouraged. There is a strong emphasis on practising functional tasks, and on the therapists' skill in designing the environment so as to enable the patient's (correct) movements.

Quantitative research comparisons of various approaches have been performed. All but one study (Langhammer and Stanghelle, 2000) which found some benefits of the movement-science approach, have found no evidence for the superiority of any one approach (Effective Health Care, 1992; Ashburn et al., 1993; Intercollegiate Working Party for Stroke, 2000). Furthermore, on the whole, quantitative research on stroke physiotherapy has yielded what has been described as 'moderate' or equivocal evidence of its effectiveness (Ashburn et al., 1993; Jeffrey and Good, 1995; Rudd and Robinson, 1996). A frequent criticism of these quantitative comparative studies is that descriptions of the actual content of treatments have been very limited in detail (Ashburn et al., 1993; Rudd and Robinson, 1996; de Souza, 1998; Medical Research Council (MRC), 1998). This has led to calls for systematic investigations and explanations of what it is that therapists actually do, and for development of clear definitions and descriptions of practice (Ashburn et al., 1993; Wolfe et al., 1996; de Souza, 1998; MRC,

1998). It is argued that this information will facilitate the design and conduct of more fruitful studies of specific skills.

2.7.2 Attention to communication in stroke physiotherapy approaches

Although communication and the patient therapist relationship is acknowledged in textbooks as central to therapy's effectiveness (Carr and Shepherd, 1987; Bobath, 1990), the vast proportion of texts and training courses is taken up with identification of movement abnormalities and therapeutic strategies to restore normality. Stroke and neurophysiotherapy texts generally confine their consideration of communication to a limited range of specific elements. In Bobath, touching the patient (referred to as 'handling' or 'guidance') is emphasised. Through touch, the therapist assesses qualities of patients' muscles and movements. Through handling, the therapist re-educates movement, giving the patient the sensation of normal movements, facilitating normality and inhibiting abnormal movements (Davies, 1985; Ryerson and Levit, 1997). Carr and Shepherd's movement science text (1987) notes the importance of clear, succinct explanations of exercises through speech and demonstration, and provision of accurate verbal feedback. There is less emphasis on touch. They indicate that verbal feedback should be brief, and provide patients with knowledge of their performance and the success or otherwise of their efforts. Davies (1985), whose approach closely follows Bobath, discourages talking to stroke patients during guided activities: "When guiding the patient the therapist does not give him verbal instructions or feedback. Her voice would distract him from the activity" (p6) or make him dependent on the therapist's instructions.

Other Bobath-influenced texts do not so explicitly proscribe verbal communication, but often imply that at the stage when patients are being offered manual guidance to re-educate movements, verbal communication should be minimised, at least during performance of movements (Bobath, 1990; Lynch and Grisogono, 1991; Ryerson and Levit, 1997).

In summary, physiotherapy texts tend to emphasise technical rather than communicative, interpersonal skills. There is some attention to communication in neurophysiotherapy texts, but this is limited and specific. The most prevalent British approach to physiotherapy for stroke patients pays considerable attention to touching or 'handling', but the focus is on touch as a therapeutic technique rather than as an interactional resource. Little attention is paid to other aspects of communication, although praise and encouragement are regarded as important (Lynch and Grisogono, 1991). Movement science based approaches are also influential on British practice, and pay more specific attention to verbal and non-verbal communication, though within fairly narrow technical confines of instruction and feedback. Across approaches, verbal communication tends to be specifically discouraged during movements that are being physically guided by the therapist: it is argued that this would 'distract' the patient.

2.8 *Features of stroke physiotherapy within inpatient rehabilitation that make it a valuable setting for studying physiotherapy communication*

As explained, stroke is a common disabling condition for which patients regularly receive physiotherapy, often in hospital 'stroke unit' settings. Thus *the setting studied is one in which physiotherapy commonly takes place*. We also noted that somewhat equivocal and 'moderate' findings of stroke physiotherapy's effectiveness in quantitative studies have led to calls for more detailed descriptions of treatment processes. *This setting has parallels with many others in which physiotherapy is performed*. These include the considerable use of both talk and touch in stroke physiotherapy, and other patient and therapy-related factors. These patients are fairly recently disabled, and in a period of having to adjust to disabilities. They have impairments of movement which make mundane aspects of daily life (e.g. walking and dressing) difficult. As in many physiotherapy settings, therapists' work here includes assessing and correcting patients' impairments of movement and teaching patients about movements. However, we should note that in other physiotherapy settings, patients' symptoms of pain and therapists' management of these form a more central and common feature of treatments. Further features that make this a valuable setting for studying interactions are that patients admitted to stroke rehabilitation wards have *a range of forms and severity of disability*, also, because this rehabilitation usually lasts some weeks, patients present in this setting have *a range of amounts of experience of physiotherapy*. In addition, physiotherapy treatment sessions in stroke rehabilitation are relatively lengthy (usually at

least 30 minutes long), and *include a variety of therapeutic activities*. Thus, numerous aspects of the stroke rehabilitation setting make it one that is likely to be a fruitful one for studying physiotherapy interactions, and that will be likely to include a range of circumstances and interactional activities that commonly occur across many physiotherapy settings.

2.9 Conclusions

This review has encompassed a range of literature on communication in physiotherapy and in stroke rehabilitation. We have considered published commentaries, clinical texts, and recommendations for good practice, and also ethnographic studies, qualitative interview studies, and quantitative studies which categorise communication conduct and measure external and psychological variables' influence upon it. We noted that the latter approach seems to have been most frequently utilised in previous studies of communication in physiotherapy. We detailed many limitations of this method, and argued that as a consequence, findings from such research are simplified to such a degree that they fail to address important conceptual and practical issues, and hence their applications are limited.

The ethnographic studies of physiotherapy communication we reviewed also have limitations. Two studies that focused on experienced therapists' communication identified forms of conduct that differed from that of novices. However, the descriptions of this skilled conduct were not of sufficient depth to provide therapists with the sort of information they would need were they to acquire and implement these skills. Another body of ethnographic research (by Thornquist) focused on detailed description of communication practices of relatively experienced practitioners and of patients during recorded therapeutic interactions. However, we argued that findings were overly interpretive and evaluative, and that some claims were not properly grounded in the data. As in some other studies, the critical approach

adopted assumed *a priori* that professionals dominated, and patients were passive, such that therapists constrained patients' expression of their views.

Running through most of the literature are several criticisms of both rehabilitation and physiotherapy. It has been argued that physical aspects of recovery are overly attended to at the expense of dealing with patients' social and psychological needs, and at the expense of patients' self-determination. In physiotherapy this emphasis is said to involve a failure to appropriately balance and integrate attention to patients as bodies and as subjects. It has also been suggested that the value physiotherapists place upon 'normality' means that the goal of return towards normality and physical independence is imposed on patients, and the wider context of their disabilities ignored. We remarked that this critical literature often draws upon, and is generated from, a particular perspective on professional patient relations. This perspective views professionals as oppressive and dominant with the result that patients are passive, under-informed, and are not allowed to be involved and active in their own treatment nor encouraged to express their own views. We noted that this perspective has been challenged by investigations that have paid close attention to the dynamics of interactions, but have delayed further discussion of this research until subsequent chapters.

Previous literature has identified various difficulties and challenges that arise in physiotherapist stroke patient communication. These include differences in perspectives on and expectations of treatment, a reported tendency of patients to become highly dependent on therapy, and hence a difficulty in

realising the goal of patients' independence. Other difficulties include problems that arise when patients' communication is limited due to language or cognitive impairments.

Despite the various criticisms and problems, communication is regarded as a key component of physiotherapy, and several commentators have noted both significant benefits of 'good' communication and drawbacks of poor communication. However, research into the topic is sparse, and, we argued, of poor quality. Because of the limitations of current research into physiotherapy communication, its small volume, and its disparate topical foci, there are few findings that are especially relevant and informative for the current study. However, we did note that many studies have found variations in conduct between therapists and between different settings and medical conditions, thus we must not blindly assume that practices seen in our data will necessarily be found in other areas of physiotherapy practice. Another area of findings which we will reflect upon during analysis are those that claim therapists dominate passive patients, and that they 'separate' the person and the body of patients, so failing to integrate therapeutic and social communication with them.

One area of literature that *is* particularly relevant to the current study concerns recommendations for good communication practice. These are highly relevant because a key element of our analysis concerns the relations between actual practice and that suggested by professional recommendations. These recommendations stress active patient

involvement in treatment, the importance of providing patients with relevant information, and of motivating patients. They suggest that patients should be treated as equals and as experts in their own right. In addition, specific recommendations derived from neurophysiotherapy texts recommend that talk with patients during treatment activities should be limited so as to avoid distracting them.

We can conclude from this review that communication is recognised as a vital component and a core competence of physiotherapy, but has been under-attended to by research and by texts on practice. Where research *has* been conducted, the methods used have considerable deficiencies. Nevertheless, in the current policy climate, which emphasises patients' active involvement in healthcare, and partnership and equality in their relationships with professionals, recommendations for good practice in physiotherapy emphasise communication, and include fairly extensive guidance to physiotherapists about it. However, perhaps because of the dearth of research on physiotherapy communication, these recommendations have little grounding in empirical studies. We have implied in this chapter and the previous one that elements of this guidance may be problematic because they are not based upon detailed understanding of the process and contingencies of 'real life' physiotherapist patient communication. We would also argue that since so little is understood about communication in physiotherapy, this makes for difficulties in both training and ongoing improvements in practice.

The current study aims to develop detailed descriptions and explications of physiotherapists' and stroke patients' communication practices through application of an ethnomethodological conversation analytic methodology. Analytic claims will be grounded in orientations of participants that are apparent through repeated inspection of the recorded data. Before presenting these analyses, we will describe in detail the methodology and methods applied in the current study.

CHAPTER THREE

METHODOLOGY AND METHODS

3.1 *Introduction*

This chapter describes the methodological approach adopted in this study – ethnomethodology and conversation analysis (CA) - and the study's design and methods. We will outline central notions and concepts of ethnomethodology and CA to provide a general backdrop for the study, and to introduce elements that are especially relevant to the interactional topics on which this thesis focuses. We will explain how and why this approach potentially overcomes shortcomings apparent in other research methods that have been applied to physiotherapy communication (see previous chapter). Additionally, we will explain why this approach is particularly relevant and appropriate for researching physiotherapy interactions, and argue that its potential for productive findings is considerable.

The chapter is structured as follows. First, we summarise the main problems and deficiencies of alternative research methods which we highlighted in the previous chapter. As we do so, we will introduce ways in which ethnomethodology and CA overcome these. Next we describe ethnomethodology, the broad intellectual framework upon which CA is founded, and explain ethnomethodological understandings of human conduct. We go on to describe the methodological principles and fundamental assumptions and aims of CA research. We will then consider

how institutional interaction is understood and studied within ethnomethodology and CA. Later in the chapter, we describe the methods of this particular study.

3.2 An introduction to how ethnomethodology and CA overcome problems of other research approaches

Various criticisms of other research approaches were discussed in the previous chapter, these can be summarised within two main themes. First, those arising as a consequence of the assumption that communication conduct is governed by sets of pre-existing factors: 'external variables' and internal properties and cognitions. Second, those arising as a consequence of describing interactants' activities according to terms imposed by the researcher(s).

Much previous research into physiotherapy communication has viewed communication conduct as determined by external variables (e.g. gender, number of years of experience as a practitioner), and/or by 'internal' factors (e.g. attitudes) that are assumed to be stable and consistently held. This view arises from schools of thought within social psychology, and also from certain notions within sociology, particularly Parsonian analyses of social conduct (see Section 3.3). The problems that arise from this approach include:

- Trivialising the role of human reasoning and agency – people's conduct is seen as determined by other factors

- Premature imposition of analysts' decisions as to the external variables and categories of communication conduct that are considered relevant and meaningful
- A tendency to (artificially) separate conduct into individual elements and treat these in isolation, e.g. investigating therapist and patient conduct separately, sometimes only considering one party's actions, and also separating talk and body movement 'channels'. Thus failing to examine the relationship and collaboration between participants and between 'channels'
- We have argued that as a consequence of the above, attention is deflected away from details of the data, and analysis fails to adequately see, describe and understand participants' actual conduct within the interactions studied. As a result, findings are insufficiently detailed to be practice-relevant and applicable

Ethnomethodology and CA offer a very different conception of how conduct comes to be organised and understandings shared between people.

Meanings and context (social situations) are seen as *locally* accomplished rather than governed by variables external to the interactional situation. Also, interaction is understood as inherently collaborative: those present constantly participating in, and constituting interaction and meaning whether speaking or not. Their methods offer a means of investigating both talk and body movement, which are viewed as functioning together and closely related. They avoid categorising actions and their functions simplistically or prematurely.

Moving to the other main theme, we argued that much previous research entails an over-simplified conception of description, failing to recognise that description is inevitably selective and involves interpretation of what is important and relevant. Associated with this inherent selection and interpretation is a tendency to privilege the analyst's interpretation of what is relevant, salient, and of 'what is really going on'. This perspective, in which social scientists are seen as uniquely capable of *seeing through* people's claims and activities and thus grasping what is *really* going on, has been a prevalent one within sociology (Silverman, 1997). As a result, findings are not rigorously, empirically grounded, data are prematurely interpreted, and there is a lack of procedures for warranting whether interpretations made are more valid than other possible interpretations. Often associated with this viewpoint is an evaluative and sometimes rather condemnatory approach (especially of professionals' conduct).

Ethnomethodology and CA see people's actions as accomplishments and as methodical strategies for solving the various challenges inherent to human interactions. The emphasis is upon close consideration of the features, preceding actions, and interactional consequences of people's patterns of conduct. This approach seeks to privilege the orientations and interpretations of the interactants themselves, and provides principled methods for doing so. Descriptions and interpretations can then be warranted on the basis of their observable relevance to participants themselves. Analysts avoid evaluating people's conduct; instead, they look

for the logic of their activities (Silverman, 1997). This is part of the wider methodological constraint of 'ethnomethodological indifference' wherein the analyst refrains from making judgements which have the effect of endorsing or undermining people's conduct (Heritage, 1987). This is an especially useful stance for research in medical settings in which so much research into interactions has been highly critical (e.g. Stevenson et al., 2000, Thornquist 1994a). This alternative approach would seem far more likely to produce constructive findings because it emphasises informing, rather than condemning, practice.

We will now elaborate upon ethnomethodology and CA, exploring how and why they offer a particularly useful and appropriate approach to studying interactions in general, and physiotherapy interactions in particular.

3.3 *Ethnomethodology*

The term ethnomethodology was coined by its founder, Harold Garfinkel. It refers to the study of "the body of common-sense knowledge and the range of procedures and considerations by means of which the ordinary members of society make sense of, find their way about in, and act on the circumstances in which they find themselves" (Heritage, 1984, p4). Thus, it investigates the "elementary properties of practical reasoning and practical actions" and how people "recognize, produce and reproduce social actions and social structures" (Heritage, 1987, p225-6). It is a broad and complex field of understanding – concerning itself with explaining, understanding and detailing how people conduct themselves in social situations, and how

shared understandings of one another's actions are established and maintained so that actions are mutually intelligible. Ethnomethodology recognises that central to shared or *intersubjective* understanding is the local context of action, along with a framework of 'normative accountability of action' (Heritage, 1987). As these concepts and understandings underlie the approach used in this study, explaining them will provide a background to its methods and analysis. In this discussion we draw particularly on Heritage's seminal texts on Garfinkel and ethnomethodology (1984, 1987)⁵.

Ethnomethodology developed at a time when the *Parsonian theory of social action* was highly influential upon sociologists' understandings of how and why people act as they do, and how society comes to be organised and orderly. This theory holds that people's striving towards normatively valued ends underlies and determines social conduct. It also holds that where conduct is not motivated by scientific rationality, motivation consists of internalised moral values – a 'central value system', learned through childhood socialisation and reinforced by reward and punishment. This is a highly truncated version of Parsons' work, and we will return to aspects of his analyses rather more specifically in Chapter 4, Section 4.5. For now we will discuss the relationship between Parsons' work and the development of ethnomethodology by Garfinkel. In doing so, we will introduce some key concepts of ethnomethodology.

⁵ These texts are particularly helpful in the light of Garfinkel's 'difficult and dense' (Heritage, 1984) and at times "opaque and cryptic" writing style (Heritage, 1987, p224).

Garfinkel, whose postgraduate studies were supervised by Parsons, held Parsons' work in high esteem and viewed it as raising questions of key importance to sociology. However, he was dissatisfied with some elements of Parsons' theories, and sought to further investigate and indeed to operationalise issues which they raised. These particularly concerned the role of social actors' own knowledge and understandings in shaping social actions, and the nature and origins of mutual shared knowledge and understandings. Whereas Parsons emphasised construction of theory and did not empirically test his ideas, Garfinkel proceeded by developing programmes of empirical investigations of social conduct (we refer to some of these subsequently, see Chapter 6, Section 6.9). As his work progressed, Garfinkel formed "fundamental disagreements" (Heritage, 1984, p33) with many aspects of Parsons analyses.

One element of Parsons' analyses which Garfinkel sought to address concerned how seeing conduct as determined by standardised, internalised norms diverts attention away from the local methodological sense-making procedures through which people manage their interactions. Also, how such an analysis "forestalls appreciation of the indigenous perspectives of the actors themselves" (Clayman and Maynard, 1995, p3). Instead it treats people as 'blindly' responding to pre-existing moral values, as Garfinkel put it, it treats them as 'judgmental dopes'. Relatedly, where actions are not seen as having a 'scientific explanation', they are treated as 'irrational' and explained in terms of internalised norms. That is, conduct is measured against a particular yardstick or "privileged version of social structure"

(Heritage, 1987, p231). This measuring of conduct against a yardstick 'held' by the analyst has similarities to the pattern seen in some physiotherapy communication studies – where the yardstick or privileged view concerns normative views of good practice (e.g. Jones et al, 1998).

Ethnomethodology's approach on the other hand, is to suspend commitment to such privileged versions in favour of carefully studying the detail of participants' actions. Rather than evaluating conduct against some external yardstick, the analyst looks for the logic and 'good sense' in what participants do (Silverman, 1997).

Garfinkel reconceptualised the role of norms in conduct. He highlighted the unfeasibility of assuming that a set of norms could encompass every situation, or that each person could have a store of these, shared in common with all others and activated in a uniform way in particular situations. Instead of seeing situations as causing specific norms or rules to be invoked, then certain actions to result, he saw actions and interactional situations as part and parcel of each other, so that situations are products of actions.

However, this raises a question: without this notion of shared normative prescriptions determining conduct in each situation, how does ethnomethodology propose that people recurrently act in ways that are intelligible to each other? The answer involves proposing a different role for normative rules and expectations in relation to conduct. In this conception, they are interpretive rather than regulative. Ethnomethodology does not deny that (adult) people expect each other to share a considerable volume of knowledge, practices and procedures, and bring these to their interactions.

However, this is not to say that their conduct will necessarily *comply* with these normative expectations and practices. Nevertheless, because people are assumed to *know* if and when their conduct represents a departure from expectations and conventions, others will assume any departure is *motivated and intentional* in nature; and will tend to impute or seek explanations.

Greetings sequences offer a simple example to illustrate this. If on approaching another, a person says “hello”, then a response – “hello” or similar – is expected (or ‘preferred’ to use a term we will explore further in Chapter 5). Provided an individual can be held to be aware of norms, and capable of responding, and if no response is forthcoming, the first speaker will make various interpretations⁶ and may pursue a response or explanation (an ‘account’) for its absence. Whereas, if the expected response *is* forthcoming, people tend not to treat explanation or account as required. Furthermore, a person responding or refusing to respond will know the likely interpretations or consequences of their actions. This system has several features. It provides ‘good reasons’ for complying with norms (Heritage, 1987). It means that no conduct is uncategorisable: meaning and understandings can always be furnished by the norm or convention, even

⁶ In stroke physiotherapy, making these interpretations can be particularly difficult. As described in the previous chapter, cognitive awareness and also the ability to respond physically and verbally can be impaired in stroke. This can make it difficult for therapists to interpret ‘failed’ or unexpected responses. Explanations for these include not only the range of explanations one might consider with ‘non-disabled’ adults, but possible clinical or

where it is not complied with. That is, any actions can be understood as making sense. Also, these normative expectations are self-sustaining because of the way that non-compliance results in comment and explanation or sanction. A further consequence of the system is that breaches and departures from normative expectations can transform situations of action and local social identities. For instance, in the case of non-response to a greeting, the recipient might be transformed from, for instance, 'friend and colleague' to 'person in a bad mood', or 'person who is snubbing me for some offence'. Thus, rather than governing and determining conduct, norms, rules and conventions "are primarily to be understood as resources for establishing and maintaining the intelligibility of a field of action" (Heritage, 1987, p245).

In summary, Garfinkel's conceptualisation of the role of rules and how people make sense of one another's actions contrasts with Parsons' notion of rules in several ways. Rather than seeing rules as external, pre-determined and clearly defined, ethnomethodology sees them as developed and understood in and through ongoing actions. Garfinkel also highlighted the way that rules form sense-making devices rather than merely regulating conduct. He saw rules not as *impelling* people to act in accord with them, rather, that they tell us what to expect, what is 'supposed' to happen, and hence provide grounds for members of society to analyse and interpret the reasons for actions,

pathological reasons too. Interpretation is especially difficult because cognitive and 'high level' language impairments are not always easy to detect and diagnose.

whether or not these actions are in accordance with normative rules and expectations. That is, people are held accountable for their actions.

3.3.1 Accountability

Garfinkel uses the term accountability to refer to two features of social activities (Heritage, 1984; Peräkylä, 1998) which we have already touched upon. One aspect of accountability concerns the way activities and settings are routinely observable and intelligible (through normative expectations) without participants actually focusing on making them so. Garfinkel termed this 'incarnate accountability': we understand much of what goes on without explicitly detailing, talking etc. about those understandings. The other aspect "involves 'accounting' as a distinct activity" (Peräkylä, 1998, p302) such that "when routine production or recognition of activities is breached, the actors are held explicitly answerable for their actions ... [and are] expected to be able to give reasons for whatever they are doing" (Peräkylä, 1998, p302). This study will consider both aspects of accountability. We will explore what therapists and patients do and do not seem expected to explain during interactions: which phenomena and actions seem taken for granted and 'incarnate' within physiotherapy sessions, and which are treated as meriting explicit accounts. This will help build understanding of the knowledge and normative expectations that people bring to physiotherapy interactions, and will thus advance understandings of how these interactions function.

3.3.2 *Context*

A further element of ethnomethodology we need to explore concerns understandings of context. The context – the situation of the interaction - concerns both the local configuration of preceding activity in which actions occur, and the larger environment of activity within which this local configuration occurs (Drew and Heritage, 1992). In some approaches, including the ‘social psychology’ model explored in the previous chapter, context is seen as independent of interactants’ own activities. This has been described as the ‘bucket theory of context’ wherein “some preestablished social framework is viewed as “containing” the participants’ actions” (Drew and Heritage, 1992, p19). In ethnomethodology, context is understood to be “both the project and product of the participants’ own actions and therefore as inherently locally produced and transformable at any moment” (Drew and Heritage, 1992, p19), it is built up or re-created through interactions (ten Have, 1991). That is, this approach sees meanings and social order as “ongoingly accomplished in and through the practical and concerted actions of the participants themselves” (Heath, 1997, p186).

These understandings of how people accomplish social organisation, conduct, meanings and intersubjective understandings have important consequences for the methods by which interaction is studied, and also the perspective on people’s conduct that analysts take. In terms of methods, rather than invoking and measuring external or psychological variables, or seeking to discover regulative rules of conduct, analysts study closely the practical actions, procedures and apparent reasoning through which people

interact. Furthermore, people are not judged as either succeeding or failing in some way to follow rules or norms. Instead the reasons and logic underlying their actions, and the orientations that their actions (and at times their explicit accounts) reveal are explored. People are seen as *accomplishing* social actions through their skilled interactional activities.

The view of context, understandings, and roles as dynamic and transformable through interactants' own local activities is an inherently optimistic one with regard to potential for change. People are not seen as 'dopes', conforming to external variables that are fixed and 'pre-destined'. Instead, they are seen as capable of accomplishing and transforming meanings, understandings and actions through their local conduct. For this study, which is concerned with professional practice, this view of people's actions as representing intelligible and 'reasonable' accomplishment within particular circumstances, and also of roles and actions as transformable and flexible, seems to offer a potentially fruitful and positive approach. It contrasts sharply with the rather condemnatory tone of some research on communication practice in physiotherapy and rehabilitation (see Chapter 2). We will see shortly that this view of context as interactionally accomplished has important implications for studying institutional interaction.

We have briefly summarised a topic about which whole books have been written (e.g. Benson and Hughes, 1983; Heritage, 1984; Sharrock and Anderson, 1986). Nevertheless, core concepts of ethnomethodology have

been outlined, providing a foundation for understanding the analysis contained within this thesis and for understanding CA, to which we now turn.

3.4 Conversation analysis

Describing the objectives of CA in broad terms, Greatbatch et al. (1995a) explain that: “CA researchers aim to describe the procedures, rules and conventions which participants use in producing their own behaviour and interpreting and dealing with the behaviour of others” (p32). Despite its name, CA can be, and is applied across many forms of interactions including institutional interactions (e.g. Peräkylä, 1998; McHoul, 1985). It can also encompass analysis of body movements such as gaze (e.g. Goodwin, 1979), touch (e.g. Heath, 1986), gesture (e.g. Schegloff, 1984) and physical interaction with material objects (e.g. Greatbatch et al., 1995b). Central to CA studies is the analysis of mechanical recordings of ‘naturally occurring’ interactions. It is a qualitative form of analysis which emphasises consideration of actions in sequence rather than in isolation. Before further discussion of the analytic methods of CA, we will describe the principal understandings that underlie it, particularly as described by Heritage (1984, 1997). Our discussion is also informed by writings of Silverman on Harvey Sacks’s work (1998), of ten Have (1999), and of Schegloff (particularly 1997 and 1999).

CA embodies a theory with several elements (Heritage, 1997). It holds that *interaction is structurally organised*, having systematic and orderly properties which result from conventions and practices independent of psychological and

other characteristics of individual interactants (Heritage, 1988a). It holds that *contributions to interaction are contextually oriented*. That is, each utterance in an interaction is addressed to preceding ones⁷, most commonly those immediately preceding it. In this way, utterances are 'context shaped'. Furthermore, utterances are also context creating, or renewing, or maintaining, in that they normally project and require some next utterance by a subsequent participant (Heritage, 1997). This 'contextual orientation' is important in establishing intersubjective understandings. When a next (second) action is produced, this shows what sense has been made of the prior action; it makes understanding publicly available. In a subsequent (third) turn, this displayed understanding can be confirmed or be an object of correction or repair. This makes for an ongoing *sequence* wherein understandings are made available and developed into mutual understandings. The way participants' understandings are inherently hearable and observable within interaction through its sequential structure is highly important for analysis, as we will explain further below.

The CA approach also sees *intersubjective understandings as built from the detail of interaction*. For this reason, no order of detail is dismissed *a priori* as irrelevant. This principle has been shown to be important through various empirical analyses, an example is work by Pomerantz (1984) who shows that pauses and delays in producing utterances are an important part of the way

⁷ This contextual orientation also applies to non-verbal activities, however, their sequentiality is not always so tightly organised in terms of projecting or requesting relatively immediate and responsive next actions (Heath, 1997).

we understand one another's actions. Another example is Simmons-Mackie and Damico's (1996) work on apparently 'low profile' vocalisations and gestures by which they found a dysphasic⁸ person managed her conversations. This principle wherein no detail of conduct is dismissed *a priori* links to a wider methodological restriction wherein premature interpretations and decisions about what is important or relevant within an interaction are avoided. Instead, analysis aims at empirical, detailed description of actions and sequences so that "empirical analyses [are] answerable to the specific details of research materials" (Heritage, 1984, p243).

These stipulations, along with the reliance on *recordings* of interactions (rather than, for example, field-notes), help lead to the distinctively rigorous approach to data analysis adopted by CA (Clayman and Gill, forthcoming). This offers a means of overcoming aspects of the over-interpretive approach for which we have criticised some other studies of communication in physiotherapy. We noted the way these tended to privilege the analyst's interpretations, and to implicitly claim to uncover hidden meanings – 'what is really going on'. No such claims are made in CA (ten Have, 1999), rather, "the understandings that matter are those that are incarnate in the interaction being examined - understandings that participants act on within interaction and thus render consequential for its subsequent development" (Clayman and Gill, forthcoming). That is, the meanings and interpretations that are privileged are those of the participants themselves (Schegloff, 1997). This is analytically feasible because these meanings and interpretations are available in the

⁸. Dysphasia means impairment of language and word production.

sequential organisation of interaction. Therefore, rather than “simply stipulate the meaning or significance of particular utterances in the light of their own personal intuition, researchers can inspect subsequent actions in order to determine how the participants themselves are responding to, and displaying their understanding of, each other's conduct” (Heath, 1997, p189). This allows for a principled approach to description and interpretation of action, and forms a vital validation or ‘proof’ procedure in CA (Peräkylä, 1997). However, it must be acknowledged that things are not always so “nice and simple” (Peräkylä, 1997, p209) as this: people’s utterances, actions and responses are sometimes designedly ambiguous, or absent altogether (Heritage, 1984), so that understandings are not at all transparent. For this reason, a sufficient volume and variety of data, and a sophisticated approach to analysis is needed, allowing ambiguities to be discerned, and also allowing systematic consideration of how activities are deployed as well as responded to.

3.5 *Institutional interactions*

We are now in a position to consider the study of institutional interactions, i.e. interactions that take place in workplaces, service organisations and other institutions. We will describe some of the principles that guide CA studies of institutional interactions, and summarise distinctive characteristics of institutional interaction as understood and found by this approach.

The *ethnomethodological view of context* is retained: as Drew and Heritage (1992) explain: “the institutionality of an interaction is not determined by its setting. Rather, interaction is institutional insofar as participants’ institutional

or professional identities are somehow made relevant to the work activities in which they are engaged” (p3-4). This understanding leads to careful description of participants’ activities and their functions and consequences, and also avoidance of seeking or assuming external *a priori* ‘institutional’ factors to explain observed activities.

CA studies of institutional interactions usually entail, whether implicitly or explicitly, *comparison with the practices of ordinary conversation*. There are principled reasons for doing so. The practices and organisation of ordinary conversation are primary in the sense that this is the first form of spoken interaction we encounter and learn as children, and forms a benchmark against which we recognise and experience other forms of interaction (Drew and Heritage, 1992). It also appears to be the original source of practices that, in institutional contexts, get specialised and adapted (Clayman and Gill, forthcoming). Comparative analysis allows identification of what is distinctive in the patterns of institutional interaction, and illumination of the functions of those differences.

Another feature of CA studies of institutional interaction is the way that, as in all CA studies, *findings are cumulative and interlocking*. Although the ‘basic object’ of research is more confined in studies of ordinary conversation, and although institutional settings can differ widely in terms of the sorts of tasks conducted and the formality of the structures of interaction (Sacks et al., 1978), findings across different institutional settings can nevertheless inform one another. In the current study, studies of other institutional interactions,

particularly between doctors and patients, and to a lesser degree in classrooms, inform analysis at various points (e.g. Chapter 5).

Cumulative empirical study has illuminated *particular characteristics of institutional interactions*. Drawing on Drew and Heritage (1992) these are that:

- At least one of the participants is oriented towards some “core goal, task or identity” (p22)
- There are particular constraints upon what sorts of actions and utterances are treated as allowable contributions to the interaction
- There is a restricted, specialised range of practices compared to that in ordinary conversations
- Particular, specialised, forms of inferential links or procedures may operate
- Associated with these characteristics are differences in the rights, obligations, and opportunities of different participants to initiate and to sanction interactional activities

Thus, CA studies *acknowledge that restrictions and asymmetries in the activities of different participants in institutional interactions exist*. However, CA’s view of these asymmetries, and particularly their origins, differs from approaches which see institutional interactions as governed by fixed *a priori* institutional rules and roles, and which assume that the institutional incumbent dominates interactions and unilaterally imposes asymmetries. The understanding of context as dynamic and locally created, and the way

conventions and norms are understood as interpretive rather than regulatory, means that patterns and practices seen in institutional interactions are understood as collaboratively accomplished rather than imposed upon one party by another. Further, they are understood to be dependent upon local interactional actions, and as constraining, but not preventing various forms of conduct (Drew, 1991).

One further consideration regarding studying institutional interaction that is especially relevant to this study concerns Garfinkel's '*unique adequacy requirement*'. This proposes that without intimate knowledge of the practices, skills and underlying knowledge that are specific to the occupation studied, the analyst will inevitably fail to grasp the nature of the work. Thus Garfinkel proposed "that the researcher be a competent practitioner in the domain of activity under investigation" (Heritage, 1987, p264). He proposed this in relation to the 'studies of work programme', a further development of ethnomethodological research (discussed in Heritage, 1984, 1987). These studies include use of ethnographic observational and descriptive methods to identify the "specific material competencies" (Heritage, 1984, p302) by which various forms of occupation are accomplished. While the current study is primarily a conversation analytic study, the notion of unique adequacy is worth discussion because it raises questions about the impact upon analyses of the analyst's competence (or lack thereof) in the occupational field studied. The researcher in the current study qualified as a physiotherapist 12 years before the research began, and specialised in stroke rehabilitation. Thus she fulfilled Garfinkel's stipulation. However, while there are advantages of being

a competent practitioner in the field of study, there are also disadvantages. We discuss these matters in more specific terms later in this chapter when we describe the methods of this study (see Section 3.8).

3.6 *Methods in CA*

Several authors have likened the methods of CA to those of naturalists (Heritage, 1988b; ten Have, 1999; Clayman and Gill, forthcoming). This analogy helps convey the way that conversation analysts gather a range of specimens (of recorded instances of naturally occurring interactions) in order to subject them to systematic analysis and comparison. Studies aim to identify recurring patterns of conduct and to describe these clearly and precisely in terms of their structure, interactional functions and consequences. We will now consider various steps in this process.

3.6.1 *Data collection*

As noted, data are ‘naturally occurring’, this means that the interactions recorded are not produced as a result of hypothetical or role-played examples, or experiment; and that the researcher does not co-produce or provoke them (ten Have, 1999; Clayman and Gill, forthcoming). The researcher also makes efforts to minimise any disruption caused by the recording. (We discuss how recording might influence conduct, and strategies that can be employed to minimise this in Section 3.7.3).

Analysis tends to begin with a study of single cases of particular interactions. This can be justified on the basis of the pervasiveness of the forms of social conduct with which it is concerned (Silverman, 1998). Since the methodological practices by which people produce their own conduct and understand that of others are shared by members of society, much can be understood from studying just one interaction. However, it is usual to build and enrich analysis through consideration of numerous cases, including those which differ in some way to what seems to be the regular pattern (see Section 3.6.2). For this reason, it is usual to collect a volume and range of data likely to be sufficient to capture the variations in practice so as to develop a rigorous and comprehensive analysis (ten Have, 1999; Peräkylä, 1997).

In summary, the data collected are audio or video-recorded naturally occurring interactions. Data are selected so as to ensure a sufficient volume and range of interactional activities that are pertinent to the topics of study.

3.6.2 *Analysis*

We give only an outline of analytic procedures here, and will elaborate on these as we describe the methods of this particular study. Having collected and begun a first 'round' of observing / listening to the data, the analyst begins to identify sequences and incidents that are of particular interest. Inevitably, the analyst's selection at this point will be influenced by their particular interests and knowledge. However, in general, the "preferred strategy is to *start* from the data at hand, and not from any preconceived

ideas about what the data 'are' or 'represent'." (ten Have, 1999, p104). Thus whilst it is likely that analysis starts from some broad agenda of interest, at this stage, the analyst avoids setting tight limits upon their selection and their analysis. This ensures that salient aspects of interactions are attended to, even if they were not recognised to be so at the outset.

Analysis seeks to identify recurrent patterns of conduct within the practice under investigation by using inductive search procedures (Heritage, 1995). Thus, alongside detailed analysis of the particular cases that have been initially 'noticed' (ten Have, 1999) and selected, further cases in the data collection which seem to contain the same or related activities are 'collected' (often edited together onto a tape). Collecting related extracts onto a single tape allows them to be viewed or listened to repeatedly in a systematic way, so as to build comprehensive analysis of activities. In forming collections, a wide net is cast so as to ensure comprehensive analysis of a phenomenon (Clayman and Gill, forthcoming). Therefore, besides identifying and analysing sequences which represent the 'regular' pattern, inductive search procedures are also used identify cases which appear to differ from the regular pattern – 'deviant cases'.

Deviant case analysis is an important way by which descriptions and proposals generated in CA are elaborated and tested for their validity (Peräkylä, 1997). The process entails searching through data for incongruous, 'irregular', cases after having initially identified some interactional regularity (Clayman and Maynard, 1995). In general, these

cases tend to ‘throw into relief’, to make all the more visible, the regular patterns. More specifically, Clayman and Maynard (1995) explain that there are three ways in which deviant cases can contribute to analyses. One is that participants can be shown to be orienting to the same considerations that produce the ‘regular’ cases. The irregular cases expose and more clearly illustrate these orientations, and how they can also generate ‘nonstandard’ cases. Secondly, deviant cases can prompt amendment of initial analysis so as to produce a more general formulation which encompasses both the regular cases and those which are less regular. Where these analytic options do not apply, it may be that some “distinctive activity is being accomplished in and through the departure” (p9), the analyst then aims to specify its distinctive nature and interactional function. Deviant cases will be examined within each analytic chapter of this thesis.

Detailed analysis of particular cases (both regular and ‘deviant’) may involve identifying various elements of their organisation. Clayman and Gill (forthcoming) explain that almost everything that occurs within interaction “is fair game for analysis”; thus it is not an easy task to summarise this process. Practical illustrations will appear throughout this thesis, here we only broadly describe the sorts of features the analyst explores. Clayman and Gill (forthcoming) describe these in terms of “nested layers” of activities. There are the *broad activity frameworks* that organise lengthy stretches of interaction, in this study these include ‘physical examinations’ and ‘goal-setting’. A step below this are *sequences of actions* with “relatively generic sequential properties”: in this study these include ‘instruction-response’ and

'problem indication' sequences. Then there are the *single actions* which are built into sequences: including instructions and evaluations. At the most microscopic level are *components of these single actions*, such as lexical choices, gaze shifts, pauses, intonations and so on. Heritage (1997), considering institutional interactions in particular, proposes "six basic places to probe" data (p164) so as to explore and reveal its institutional character.

These are:

- The *turn-taking organisation*, and particularly how and whether this differs from ordinary conversation in which the length, the order and the content of turns is more free to vary (Clayman and Gill, forthcoming); also the formality or rigidity of this organisation.
- The *overall structural organisation* of the interaction, this involves attending to whether there are specific phases of the interaction, and how phases and transitions are organised
- *Sequence organisation*, looking at how "participants initiate, develop and conclude the business they have together" and "how particular courses of action are initiated and progressed" (Heritage, 1997, p169)
- *Turn design*⁹, which includes two elements – what the action is designed to perform, and the means that are selected to perform it
- *Lexical choice*, including specialised, formal and distinctive use of terms (e.g. how and when professionals use the words 'we', 'you', and 'I')

⁹. The word 'design' and also strategy, as used in CA should not be taken to mean that the action is necessarily under direct conscious control, rather as implying that the course of behaviour is fitted to some requirement or activity (Heritage, 1990).

- *Interactional asymmetries* – differences in aspects of participation and apparent knowledge, which may be observable in each of the features above

3.6.3 *Transcription*

An important part or tool in analysis is the transcribing of either the whole dataset or of selected sequences. Transcription allows a clearer and more detailed view of data, and often reveals elements that have been overlooked during inspection of tapes. Also, transcripts can form a resource for presenting relatively ‘raw’ data within CA publications and presentations so as to allow the audience opportunities to ‘check’ presented analyses¹⁰.

Transcripts are not the primary data of CA (they are always used in conjunction with recordings), however, they are a tool by which phenomena of interest can be captured and presented (ten Have, 1999). Nevertheless, transcripts are inevitably incomplete: there will always be a further level of detail that might be included. They are selective according to general assumptions of CA and the transcriber’s own interests and limitations.

Transcripts in CA aim to capture not only what is said but *how* it is said (ten Have, 1999), this means that they include a high level of detail concerning words, intonation, silences, sounds, overlaps and so on. To add to the complexity, they may include elements of body movements: gaze, gesture,

¹⁰. ‘Framegrabs’ – still images from video-data - can also provide such a resource, as they do in this study.

touch and so on. In general, CA transcripts of verbal activities follow conventions originally developed by Gail Jefferson. They attempt “to get as much as possible of the actual sound and sequential positioning of talk onto the page, while at the same time making this material accessible to readers unfamiliar with systems further removed from standard orthography” (Heritage and Atkinson, 1984, p12). Though the conventions are open to criticism on various fronts (O'Connell and Kowal, 1995), the widespread use of a single system within CA makes for accessibility and contributes to cumulative findings and reliability (Peräkylä, 1997).

In this section, we discuss broad principles underlying transcription, rather than specific details of transcripts in this study. The transcription symbols and conventions used in this study are detailed in Volume 2.

CA transcription is particularly concerned with capturing interaction's sequential features (Heritage and Atkinson, 1984). It is a 'vertical system' in that utterances and actions are presented “one below the other in the order in which they were spoken” (ten Have, 1999, p89). Turns are transcribed on separate lines, sometimes stretching over more than one line due to limitations of space. However, a new line is begun whenever a turn by a different participant begins. Pauses and silences are transcribed, and where these occur at the end of a possibly complete turn (where other parties could take the floor if they chose), they too are given separate lines and not ascribed as 'belonging' to any one participant (Clayman and Gill, forthcoming).

As Jordan and Henderson (1995) point out, “the representation of nonverbal phenomena is in its infancy” (p86). As a result, conventions concerning its transcription are less well established than for verbal phenomena. The variety of phenomena that may be of interest in different studies may be a further contributing factor to the lack of uniformity. For instance, Goodwin (1979) utilised a very detailed transcription of gaze direction and timing, and Schegloff (1984) used a system that represented precise timing of the onset, ‘height’, and ending of gestures. Jordan and Henderson (1995) categorise different systems that have been used. One of these being ‘parallel horizontal transcripts’, where multiple horizontal lines represent talk and nonverbal activities, similar to the layout of an orchestral score. This style has been adopted in this study as it depicts fairly straightforwardly the connection of the different ‘lines’ of activity and their sequential and temporal relationships (see Volume 2).

As for all transcripts, those used in this study and presented in this thesis are not complete, nor could they aim to be. Not least because transcription is extremely time-consuming (ten Have, 1999). For instance, one second of video data took approximately one minute to fully transcribe. However, efforts were made to transcribe sufficient detail for the form and topic of analysis that was undertaken (Silverman, 1997; ten Have, 1999), and for the reader to have access to sufficient detail to inform their assessment of the analyses presented.

3.7 *Methods of this study*

3.7.1 *Participants*

The 74 video-recorded treatment sessions that form the data were recorded at four hospitals in England. They involved 21 stroke patients and ten physiotherapists.

All hospitals chosen had 'dedicated' beds occupied by stroke patients. The sites were selected from hospitals that were within convenient geographical reach of the researcher. Professional contacts and knowledge of local hospitals gained from previous research and clinical practice informed selection. Efforts were made to include both teaching hospitals in large cities and smaller, community hospitals. However, few smaller hospitals have stroke-dedicated beds. As one of the smaller hospitals did not respond to initial access inquiries, the resulting site selection was biased towards teaching hospitals. This had the advantage that larger numbers of physiotherapists and patients were included, as well as some patients who were only three or four days post-stroke. The four participating sites were three teaching hospitals (Sites 1,3,4) and one community hospital (Site 2). All had rehabilitation wards which admitted stroke patients from about five days post-stroke onwards, and two of the teaching hospitals had 'acute' beds which admitted patients immediately following their stroke. Data collection occurred during a period of two weeks (Monday to Friday) at each site, and an initial preparatory day during the preceding week.

Hospitals were first contacted by letter to the physiotherapy manager and neurological physiotherapists. After a follow-up phone call, a more detailed letter with a copy of the study protocol was sent, and a face-to-face meeting with potential participant physiotherapists arranged. At this meeting the methods and general aim of the study were outlined. After a 'cooling-off' period of several days, the therapists were contacted by phone to check their agreement to participate. Once participation had been agreed, therapists were kept up-to-date with progress of the study (e.g. ethics committee applications) by phone and letter until data collection began. Three local research ethics committees oversaw the four sites, and data collection only began once all committees had approved the project.

The therapists' details are given in Table 3a. To be invited to participate, they needed to be employed in a post at the hospital where their caseload consisted of wholly or mainly stroke and other neurological patients; to be at least 'Senior Two' level (i.e. they had completed a junior post involving placements in several specialisms for approximately two years after qualifying); and to use a treatment approach in line with current UK practice, this being the Bobath approach with or without some elements of the movement science approach. These approaches (see Chapter 2, Section 2.7.1) have been found to be the predominant stroke physiotherapy methods in the UK (Sackley and Lincoln, 1996; Davidson and Waters, 2000). Therapists also had to have consented to participation. It was almost

inevitable, given the current predominance of female physiotherapists in the UK, especially in this field, that only one of the physiotherapists was male.

Table 3a: Therapists

Therapists	1	2	3	4	5	6	7	8	9	10	TOTAL
Site	1	1	2	3	3	3	3	4	4	4	4
Gender	F	F	F	F	F	F	F	F	F	M	Male 1 Female 9
Years qualified	9	6	11	3	7	5	7	23	3	10	Range 3-23 years
Number of patients with whom recorded	4	3	5	1	1	1	1	3	3	2	*

(* Some patients were treated by more than one of the participating physiotherapists during different sessions, thus the total in this column is not the same as the total number of patients recorded)

Table 3b (page 95) summarises patients' details, for whom there were several inclusion and exclusion criteria. Patients were excluded if they had cognitive problems such that they would be unable to give informed consent, if they were unable to speak and understand short sentences in English, or if they were to be discharged in the next day or two. The inclusion criteria were: presence on a participating ward at the site at the time of filming, diagnosis of stroke, and participation in rehabilitation treatment. The therapists first asked the patients if they would consent to the researcher approaching them, and if they did, the researcher did so and explained the project. She returned at least 24 hours later with a formal informed consent form which patients were asked to sign. If they did so, filming went ahead.

Consent was checked once more after filming was complete. In practice almost all patients who fulfilled the criteria and who the researcher approached agreed to participate. At Site 2, one patient refused because he felt he had 'too much on'. All other patients approached agreed to participate, and all gave permission for the tapes to be kept and analysed after the recording was completed. Although patient selection was as described above opportunistic, it proved possible to fulfil the aims of selection which had been formulated beforehand, namely, to include both male and female patients at various stages of their rehabilitation and having differing levels of severity of impairment. The aim was to record each patient four times over two weeks. Sometimes this was not possible, usually due to discharge home, occasionally due to a patient's illness.

Table 3b: Patients

Patient	A	B	C	D	E	F	G	H	I	J	K
Site	1	1	1	1	1	1	1	2	2	2	2
Gender	F	F	M	F	M	M	M	M	F	F	F
Days post stroke (1 st recording)	65	46	105	24	67	19	5	12	6	33	10
Age	72	74	68	85	75	67	77	69	83	64	57
Number of treatment sessions recorded	3	4	4	4	2	4	4	4	4	3	4

Patient	L	M	N	O	P	Q	R	S	T	U	TOTAL
Site	2	3	3	3	3	4	4	4	4	4	4
Gender	M	M	F	M	F	M	F	F	F	M	Male 10 Female 11
Days post stroke (1 st recording)	10	33	3	9	4	56	16	22	9	22	Range 3-105 days
Age	65	63	77	52	76	63	79	86	85	71	Range 52-86 years
Number of treatment sessions recorded	4	2	4	3	4	4	4	4	2	3	

Patients and therapists were asked to sign consent forms, which gave various details including confidentiality procedures and access to recordings.

3.7.2 Selection: discussion

In selecting sites and participants, a balance was struck between homogeneity and variety of data. The aim was to have a large enough set of recordings, involving circumstances that were related but not identical, in order to reliably identify various recurrent patterns of conduct and variations in these patterns. A degree of uniformity of data was ensured by only

recording inpatient rehabilitation treatment sessions, patients who could speak and understand some English, and relatively senior therapists. By recording at four sites, including ten therapists, including patients who were at a variety of stages of rehabilitation and impairment, and recording patients and therapists several times, it was ensured that a range of circumstances that arise during inpatient rehabilitation of stroke patients were captured in the data. This enhanced the potential for findings to have validity beyond the individual setting. There were also various practical reasons underlying selection of what was recorded. For instance, hospitals that were within reach of the researcher were chosen; and recording occurred in hospitals rather than patients' own homes. This meant that better camera views were available, and more data could be captured within the time available. Inevitably, the data are selective, and we acknowledge that in other circumstances (such as treatment at home), different interaction patterns are likely to arise. We discuss the associated limitations upon the generalisability of our findings in Chapter 7 (Section 7.3.2).

3.7.3 Recording

Video data have many advantages. We describe these now, then discuss some of the problems of video-recorded data. We will then show how procedures used in this study attempted to minimise these problems.

3.7.3.1 Advantages and disadvantages of video data

Video-recordings are the optimal data when the interest is in what 'really' happened, rather than people's perceptions and accounts (Jordan and

Henderson, 1995), and video is indispensable when the physical environment, objects and bodies are central to the interaction (ten Have, 1999). Other advantages centre around the density and permanence of video recordings (Bottorff, 1991). Their permanence means they can be reviewed repeatedly and in a variety of ways, e.g. at different speeds, or by comparing and contrasting temporally separate events through editing. They can be made available for scrutiny by others, and this assists the checking of the validity and rigour of original analyses, allowing others to extend or refute them (Heath and Luff, 1993; Jordan and Henderson, 1995; ten Have, 1999). Their density means that multiple and complex elements of interaction can be analysed and there is access to a level of detail unavailable in other approaches to data collection.

Nevertheless, video data are inevitably incomplete (Bottorff, 1991; Jordan and Henderson, 1995). This is because of mechanical limitations – the lens cannot capture smell, heat or activities beyond the camera's view which *are* available to participants (Bottorff, 1991; Peräkylä, 1997). It is also selective because of choices about what is recorded (Jordan and Henderson, 1995). In deciding when to begin and end filming, choosing the camera angle, and so on, the researcher must to some degree make *a priori* decisions about what is important about the phenomenon (Kendon, 1979). Nevertheless, Jordan and Henderson (1995) argue that "video loses less, and loses less seriously, than other kinds of data collection" (p53).

A further problem of recorded data is the possible effect of recording upon conduct (Kendon, 1979; Bottorff, 1991; Jordan and Henderson, 1995). Various arguments have been made about how recording influences conduct, and some studies have reported participants' views on this. Participants often claim effects are minimal and 'quickly disappear' (Bottorff, 1991; see also Talvitie, 1996). In one physiotherapy study therapists reported they avoided discussing more 'personal matters' during recorded treatment sessions, whilst patients reported their conduct had not been influenced (Talvitie, 1996). Another claimed that experienced therapists were less influenced than novices (Ek, 1990). Several researchers claim that the camera influences different aspects of conduct differentially: that it affects verbal actions more than physical ones (Thornquist, 1995; Talvitie, 1996), and that it affects content of talk more than the structural organisation of the interaction and 'microbehaviours' such as gaze and body movements (Clayman and Gill, forthcoming; Jordan and Henderson, 1995).

Doubtless the presence of recording equipment does influence participants' conduct. Unfortunately, there is no way that any such effects could be precisely verified because it would not be possible to observe the consequences of presence and absence of observation without some sort of observation process – the Observer's Paradox (ten Have, 1999, drawing on Labov's work). Potential effects of recording and of practically dealing with these can nevertheless be considered in several ways.

Echoing some of the above arguments concerning what aspects of conduct are and are not disrupted by recording, one can propose that if physiotherapy gets done, then whatever it is that participants do in order to accomplish physiotherapy *is* being done. Further, a large part of human interactional conduct goes unnoticed by members themselves (Miller, 1997), and this would be difficult for them to change in the face of recording. Also, it is quite usual for therapy to be conducted under observation, for instance by patients' caregivers or by student therapists or supervisors. Thus recording is less of an unusual situation than one might at first think.

During our analysis, the potential effects of the camera on conduct, and the way that what was recorded might in some ways be different to what 'usually goes on' was taken into consideration. One way of doing this was to avoid in-depth analysis of certain first recordings where patients or therapists appeared, and/or reported being very nervous and conscious of the camera. Also, it appeared to the researcher that on occasion therapists were explaining actions 'for the camera', such as by giving asides that did not seem directed at the patient. This conduct was different to most of the explanatory activity that the researcher observed both during and outside recordings. Although it is impossible to definitively state that such conduct was 'for the camera', sequences that seemed to involve it were not used as primary data for analysis. On the other hand, when conduct seems clearly camera-influenced, it can be analytically useful to examine these episodes, as Lomax and Casey (1998) have shown. In the current study, one such analytical insight arose from the fact that several therapists reported that one

influence of recording was that they reduced 'social chat' with patients about their own circumstances, and indeed little talk of this sort is seen in the recordings. Therapists explained that this was because they felt such conduct was 'not very professional'. Interestingly though, one aspect of professional conduct that *is* strongly encouraged by practice stipulations is goal-setting with patients, yet the therapists very rarely did this during the recorded sessions (Chapter 6). The apparent influence of recording on therapists' conduct thus sheds some light upon what these therapists treat and view as 'professional' and what they do not.

Although one can never verify precisely how recording influences conduct, the general advice given by researchers and methodological texts is to attempt to minimise intrusiveness of recordings (Jordan and Henderson, 1995; Peräkylä, 1997; ten Have, 1999). Various strategies have been proposed. In summary these are: establishing relationships with participants such as to allay apprehension and anxiety (Bottorff, 1991), installing and leaving the camera in place as long as possible beforehand (Kendon, 1979; Bottorff, 1991), and minimally attending to the camera during recordings (Heath and Luff, 1993; Jordan and Henderson, 1995). Careful decisions should be made beforehand such as to maximise the quality of sound, inclusiveness of picture and of recording (Peräkylä, 1997). Also, recordings should be augmented with field observations (Heath and Luff, 1993). We will now describe the recording procedures used in this study. It will become apparent that each of these strategies was employed.

3.7.3.2 Practical recording procedures in this study

The researcher gained familiarity with the camera (a Cannon 8mm video camcorder UC-X40Hi), the microphones, and the tripod by using them to collect some pilot data at Site 1. This was a hospital ward on which the researcher had previously worked as a clinician, and she had close relations with staff members. This allowed her to seek detailed and candid feedback from the physiotherapists about the effects of various recording procedures. As a concrete example, at this stage several microphones were tried: a 'Sennheiser' boom type microphone, a 'PZM' microphone which lies flat on the floor, the camera's integral microphone and a radio microphone consisting of a clip-on button microphone, a transmitter and a receiver. Because other patients are often treated nearby (beyond a curtain), and because therapists remain in close proximity to patients for most of the treatment, radio microphones resulted in the best sound recordings. It would have been difficult to attach radio microphones to patients as they are frequently undressed during sessions. During piloting, the therapists reported that the transmitters, which had been attached to their waistbands with a clip, were liable to become dislodged when they moved around, and when this occurred, they became extra conscious of the microphone. As a result, small belts of a type sold as security purse-belts for travellers were purchased. The therapists wore these under their tunics, with the transmitters placed in the 'purse' section, the wire running under the therapist's tunic top, and the button clipped to their lapel. These belts and 'buttons' appeared to be minimally intrusive, not to cause restriction to therapists' or patients' movements, and therapists often wore them all day.

A few weeks after this pilot, recording proper began. Each site was visited for one day in the week prior to data collection. On this day the researcher took along the camera and microphones and began to familiarise the physiotherapists and others with these. The researcher was introduced to ward staff at this time, and initial patient contacts were made. Data collection began the following week. In the morning on each data collection day, the camera was set up in one of the gym's bed-spaces, and the therapists who were to be recorded were asked to wear the microphones for most of the day. Therapists and patients were told when actual recording was going to take place, but the presence of the camera and microphones all day for two weeks was designed to help them feel less conscious of them, thus helping reduce effects of the recordings on conduct. Prior to each recording, before patients and therapists entered the gym, the researcher placed a fresh videotape (Sony HMPHi8 90 minutes) into the camera. The tripod on which the camera stood was concealed from the bed-space behind curtains or screens, but the camera itself was visible from the treatment bed (see Figure 3a, page 104). The researcher sat at the foot of the tripod, behind the screen, taking notes during recording. Several times during each session she climbed on a stool in order to adjust the camera position so that patient and therapist were still within view even when they changed positions and moved around. The camera was turned on at the earliest possible moment: in two of the sites, this was when the therapist went to fetch the patient from the ward that adjoined the gym. As a result, sound was captured from start of contact between therapist and patient. In the other sites, the wards were

beyond the radio microphone's range, in these cases recording began as soon as the researcher heard the patient and therapist entering the gym. Recording was stopped when patient and therapist were beyond the range of the microphone receiver. The researcher used headphones in order to monitor sound during the entire recording.

scanned in photos – missing from this version

Fig 3a

On one occasion recording was temporarily halted because the therapist requested this when a patient began to cry. On another occasion, recording was interrupted by a power-cut, back-up batteries were installed and recording recommenced.

The researcher made various efforts to reduce intrusiveness and to encourage habituation to the presence of recording equipment. During initial access negotiations, and throughout the project, it was stressed to both therapists and patients that the intention was not to judge or condemn conduct in any way. Illustrations using findings of previous conversation analytic studies were useful at this time. Also, the researcher endeavoured to maintain a relaxed and positive demeanour and wore casual clothing rather than therapist uniform or formal dress. Thus, she attempted to minimise any impression of formal evaluation of practice, which might influence therapists' and patients' conduct during recordings. Looking through the camera by the researcher was kept to a minimum during recording. It has been argued that when someone looks down the camera, this tends to make it more likely that both camera and researcher are treated by others as an interactional participant, thus influencing conduct more markedly (Jordan and Henderson, 1995). Part of the consent procedure included informing patients and therapists that recording could be stopped at any time upon request, this also offered reassurance and control to participants.

3.7.3.3 Additional data collection

Field-notes and reflective notes were recorded at each site. These included thoughts about how subsequent recording quality could be improved and intrusion minimised, and insights relevant to analysis. At the end of recording at each site, the researcher met with the therapists involved. She asked them whether and how they felt their conduct had been influenced by the recording. Similar questions were posed to each patient at the end of recording. These reports were taken as informative but not as definitive descriptions of the effects of recording.

During each recording, the researcher took notes on background details such as whether other patients and therapists were in the gym but out of camera view, and technical details such as any standardised assessment procedures therapists used. Unforeseen events such as the power-cut mentioned above, and problems positioning the camera were also noted, as were the researcher's general impressions of the recording.

Each tape was clearly labelled with the site, patient, therapist, and whether it was a first, second, third or fourth recording of that patient. The date and time were recorded on the film itself.

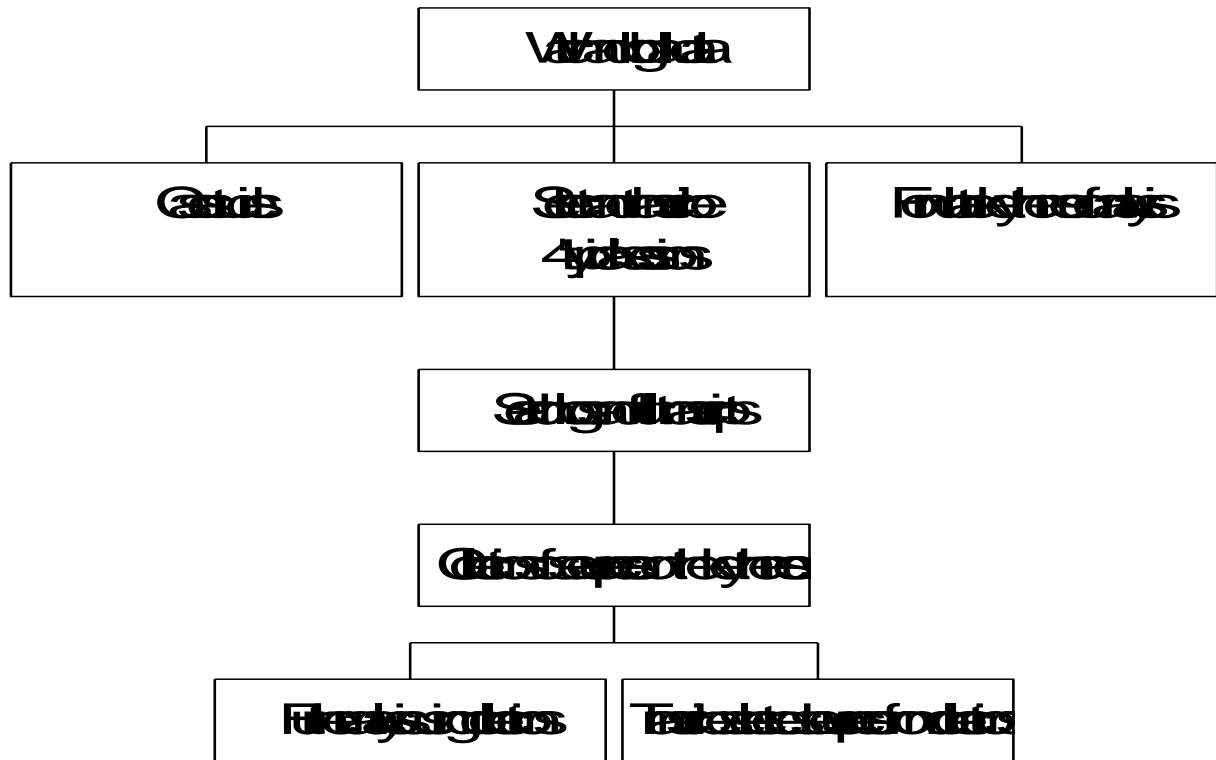
3.7.4 Analysis

We will now describe the stages of analysis (Figure 3b). Once data collection was complete, field-notes were re-read and all recordings were watched through. At this time, logs were made. In these, the researcher

attempted to list the content of each session in terms of the interactional activities occurring e.g. instructions and performance, assessment of performance, goal setting. Events that appeared unusual were noted and edited onto a collection tape. Written notes were made on emerging analytic themes. At this time, some case studies were performed based upon initial 'noticings' (ten Have, 1999). These provided an opportunity for refinement of the transcription system, particularly for body movements, as well as for development of analysis¹¹.

¹¹. Also, these case studies were used for group data sessions, and some were submitted and presented as papers at conferences (e.g. Parry, 2000a, b).

Figure 3b Stages of analysis



As there was such a large volume of data, it was decided that a clearer grasp of the detailed patterns of conduct within the interactions would be gained by full transcription of a selection of sessions. The original aim was to include one session from each site. However, at Site 4, almost all treatments involved at least three participants, and by this time, it had been decided to focus upon two-party interactions within the data. Thus, the four sessions selected included two from Site 3. The chosen sessions contained most or all elements of treatment that appeared from initial watching and logging to be typical and recurrent. They included patients who were at various stages in their rehabilitation, and who had different degrees and forms of stroke-related impairments. Body movement, gaze and talk were transcribed by hand and then word-processed. Approximately 98 hours were spent on this transcribing. These long transcripts formed a vital, highly detailed resource for subsequent analysis.

3.7.4.1 Labelling system for recordings

To help the reader follow the description of the selected sessions, we need to describe the unique label given to each recording. For instance, one of the selected sessions was “S1Ph1PaBT2”. This denotes:

- Code for the site: Site one (S1)
- Code for the physiotherapist: Physiotherapist one (Ph1)
- Code for the patient: Patient B (PaB)
- An indicator for whether this was the first, second, third, or fourth recorded session with this patient: Treatment session two (T2)

Labels for sequences we refer to in the text include an additional indicator (taken from the onscreen log) of the time of day at which the sequence took place. E.g. S1Ph1PaBT2/11.08 indicates the sequence occurred at 11.08am.

The four chosen sessions were

- Patient B's second recorded treatment: S1Ph1PaBT2
- Patient H's third: S2Ph3PaHT3
- Patient M's first: S3Ph4PaMT1
- Patient N's first: S3Ph5PaNT1

Patient B had been receiving therapy for 7 weeks, and M for 5 weeks prior to recording, Patient H had started therapy only days before, while the session selected with Patient N was the first rehabilitation session she received in the gym, when she was 3 days post-stroke. Patient B could walk a few steps with therapist assistance and had no movement in her arm. Patient H walked with minimal assistance and could move both hands. Patient M could walk with therapist assistance and had some arm but no hand movement. Patient N was unable to walk; she had a little hand movement, and also some speech difficulties. All four therapists were female, and ranged from 3 to 11 years' experience since qualification.

By this time, the key themes of analysis described in the introductory chapter had started to emerge. As a reminder, these concerned how therapists and patients interacted with respect to understanding:

- The nature of the treatment activities performed
- Achievement (success and failure) in these activities
- The reasons, goals and purposes underlying the activities

These were refined and developed during and following the full transcription of the four sessions. Analysis now proceeded by searching through both the full transcripts and the earlier logs in order to identify sequences that related to the key themes and to identify both typical and unusual episodes.

Sequences were edited together into collections for each theme, they were transcribed in varying degrees of detail according to analytic requirements. As this process continued, writing of the analytical chapters of this thesis commenced.

Thus, whilst initial identification of sequences of interest, or ‘noticings’ were inevitably “rather intuitive” (ten Have, 1999, p107), thereafter, systematic, disciplined procedures were used to build data-based analyses. These systematic procedures included the selection of four sessions for full transcribing, ensuring that the selection allowed for a variety of activities and interactional situations. Additionally, familiarity and accessibility of the whole dataset from initial watching and logging allowed a comprehensive, systematic search for sequences relating to the emerging analytic topics.

Certain other analytic activities were conducted throughout the process described above. One was ongoing review of the literature. Initially this encompassed a broad range of publications on ‘ordinary’ and medical

interactions, later it focused on conversation analytic and physiotherapy publications more closely related to the key themes. Also, data extracts were regularly shown to and explored with other researchers, who included the project supervisors, and researchers performing related work within the department and beyond it. In a workshop approximately ten months after data collection was complete, data extracts were presented to and discussed with participant clinicians. This workshop had several purposes. It supplemented earlier visits to individual participants, providing the researcher with feedback and further insights for her analysis from those who worked in the field. It provided an opportunity to both thank clinicians and to reassure them about the form and direction of analysis, and it eased the process of gaining consent which the researcher required prior to showing data extracts to wider professional audiences at conferences and meetings.

3.8 *Role of the clinician researcher*

As mentioned at the end of Section 3.5, the researcher is an experienced physiotherapy practitioner. Additionally, she had previously conducted other clinical research into physiotherapy for the arm and hand after stroke, and patients' perceptions of recovery of their arm and hand. She had published associated research papers (Parry, 1998; Parry, Lincoln and Vass, 1999; Parry, Lincoln and Appleyard, 1999), and spoken to conferences and meetings of physiotherapists (including some in the hospitals in which this study was conducted). That is, she had some standing as an academic physiotherapist. This status as experienced clinician and stroke researcher could have potential effects upon data collection in terms of influencing

participants' conduct, and upon the foci, interests, and conclusions of analysis. There was potential that the researcher might be ascribed a status of expert, and potentially, judge of the participants' conduct, particularly by the therapists. There were concerns that this might result in difficulty recruiting participants in the first place, and that it might also result in practitioners changing the way they worked and interacted with patients. Throughout access negotiations and data collection, the researcher sought to prevent these effects both through her demeanour (Mason, 1996) and through explaining the goals of the study and the non-judgmental principles of ethnomethodology and CA.

In terms of data analysis, the researcher's prior experience undoubtedly influenced the process and findings. Her clinical experience led to an awareness of 'grass-roots' problems and challenges regularly arising in the setting, and her knowledge of physiotherapy literature made her aware of issues and dilemmas identified therein. This awareness was important and influential for the study which from the outset was intended as an investigation of issues and challenges in interaction that are of practical relevance and import to practitioners. The analyst's experience also meant that she had considerable background knowledge of therapeutic procedures and specialist physiotherapy terms, which allowed her to understand the interactions more deeply and comprehensively – just as proposed by the 'unique adequacy requirement' (Section 3.5).

On the other hand, the analyst's status as competent, experienced practitioner presented potential obstacles to comprehensive and rigorous analysis. These include taking for granted elements which are in fact worthy of investigation, and the tendency to observe and evaluate activities in terms of the analyst-clinician's *a priori* views as to what constitutes good and bad practice. Also the tendency to privilege analysis of the perspective and practices of clinician participants whilst insufficiently attending to those of the patients. Various safeguards against these dangers were utilised. These included adhering carefully to the methodological stance described above, which encourages detailed, rigorous exploration and description of practices rather than glosses of them, and the associated insistence on grounding analysis in the data. Also avoiding adopting a perspective and making assertions that endorse or condemn actions, instead, seeking the logic underlying practices. Other aspects of the analytic process, particularly observation and discussion of data with non-physiotherapists and reflection upon related but non-physiotherapy literature helped counter any tendency to privilege clinicians' perspectives and practices. In fact, the researcher observed that in data sessions with others, they tended to privilege *patients'* perspectives and practices. Observation and reflection upon this helped the researcher gain broader analytic awareness of the actions of *both patients and therapists*.

Further reflection on Garfinkel's notion of unique adequacy resulted from the workshops in which data and analysis were discussed with physiotherapy clinicians. In particular, that the unique adequacy requirement should not be

misinterpreted as implying that all practitioners within a field (including practitioner-researchers) will share a common viewpoint and have similar understandings of events. To give a concrete example, in one datum shown to several practitioners a therapist pursues stepwise agreement with a patient concerning whether treatment goals have been achieved or not (S4Ph9PaUT1/2.55 in Chapter 5, Section 5.7). Most practitioners seem to evaluate what occurs as representing good practice in facilitating dialogue and explaining elements of treatment to a patient. However, one practitioner said he felt that what he observed constituted 'bullying' of the patient by the therapist. Since in the sequence itself, no explicit or implicit reference to bullying is made by the participants, there is no conversation analytic, evidence-based way to analyse whether or not the interaction constituted bullying (for the participants). Thus, as implied throughout discussion of our methodological approach, it must be for practitioners and patients or potential patients to make decisions about the appropriateness of particular practices, whilst the analyst's job is to elucidate the processes, functions and effects of practices. We discuss this issue again in our final chapter, but before this, the study's findings and analyses will be presented in the following three chapters.

CHAPTER FOUR

ACHIEVING UNDERSTANDINGS ABOUT THE NATURE OF PHYSIOTHERAPY ACTIVITIES AND OF PARTICIPATION THEREIN

4.1 *Introduction*

This chapter examines how patients and physiotherapists work towards understandings about participation in treatment activities. In order for treatment to be achieved, therapists must successfully direct and enable patients to understand the various forms of activities that constitute physiotherapy, and encourage them to participate in them. For their part, patients must find ways to indicate to therapists their level of understanding and participation.

Whilst achieving intersubjective understandings is core to all interactions (Heritage, 1984), special conditions and different demands upon participants arise in interactions where knowledge and understanding differ widely between participants. Lay professional interaction forms one such situation, particularly during initial stages. In physiotherapy, patients and therapists can be expected to bring to their interactions very different knowledge and inferential frameworks (*c.f.* Drew and Heritage, 1992) regarding the topics and bases of treatment sessions. Therapists will be familiar with physiological, anatomical and biomechanical knowledge of the body and with

technical therapeutic procedures with which patients will, at least initially¹², be unfamiliar. Patients in their turn will bring their own personal knowledge of their condition, movement difficulties, and sensations. The achievement of the tasks and goals of physiotherapy relies on establishing intersubjective understandings between therapists and patients in the face of these different forms and levels of knowledge and understanding.

In all three analytic chapters, we explore ways in which therapists and patients attempt to establish such understandings. This chapter explores a form of understanding that is central to their interactions – this concerns the nature of the physiotherapy activities to be conducted by therapist and patient together, and the nature of their participation within these activities. The extracts we examine in the chapter concern initiation and conduct of various treatment activities that are commonly performed during physiotherapy sessions. These include assisted hand and arm exercises, practising standing up and sitting down independently, and certain manual procedures which therapists conduct ‘upon’ patients’ body parts. The extracts generally include instructions of one form or another by the physiotherapist, and responses of one form or another by the patient – forming what we shall call ‘instruction-response sequences’.

¹² Lay participants’ levels of knowledge are likely to change where their dealings with professionals are prolonged (for example see Pilnick, 1998). This raises questions about whether interactional *expectations* regarding their level of knowledge also change over time; see Chapter 6, Section 6.9 and Chapter 7, Section 7.5.

We shall see in the extracts that therapists' and patients' interactional activities differ. Therapists introduce activities through various verbal and physical means including instructions, tactile physical guidance, and demonstrations of actions using their own bodies and those of patients. Patients display their understandings through their responses to instructions; usually physical ones, but they also respond verbally, especially when seeking further information or clarification about the activity.

As we describe therapists' and patients' practices, we will begin to explore what these reveal about their interactional orientations; i.e. the sorts of issues and factors that underlie and shape their conduct. One factor that appears significant is an orientation to therapists' authority to lead and orchestrate treatment activities. Another factor centres upon ways that physical incapacity and illness are interactionally managed by recipients and providers of healthcare. Analysis will draw upon previous sociological analyses by Parsons and Goffman concerning the conduct of medical interactions, and the management of physical incompetence. We will reflect upon the relationship between these analyses, and the conduct observable in the physiotherapy data. We will see that Parsons' and Goffman's works shed light upon the significance of patients' interactional conduct with regard to their physical shortcomings, and their efforts to participate in their physiotherapy treatment, and also upon the form of therapists' instructions and responses to patients. Our analysis of the orientations and phenomena that underlie conduct in this aspect of physiotherapy will introduce themes that we return to and elaborate upon in subsequent chapters.

4.1.1 *Structure of the chapter*

The first data extracts presented in this chapter exemplify key features of conduct that are recurrent in sequences where understandings about what and how treatment activities are to be performed are achieved and displayed. In the setting studied, physiotherapy encompasses a range of treatment activities that require different forms of participation by patients and therapists. So as to encompass these different forms, several data extracts will be considered. In contrast to these, later extracts will illustrate apparent *problems* of understanding. Examining how these are managed and solved will enhance description of how therapists and patients achieve understanding. We will see that these misunderstandings tend to be immediately apparent: either the patient does not perform the activity at all, or performance fails in some way. Also, that they tend to receive immediate attention. We will see that establishing and maintaining mutual understanding about the nature of activities and of participation in them is a pervasive and immediate concern for both therapists and patients, and strongly shapes their interaction.

As discussed in the introductory chapter (Section 1.5) in this chapter and the two that follow, descriptions of conduct derived from analysis of extracts will form a base for explanatory analysis which draws upon sociological analyses. Finally, analysis will turn to a consideration of how the various practices and orientations observed and described relate to published recommendations for good practice in physiotherapy.

4.2 Data analysis

The coding and labelling system used for extracts was described in Chapter 3, Section 3.7.4.1. The conventions, symbols and layout used within transcripts are presented in Volume 2. Briefly, the Jefferson system is used for verbal lines, with descriptions of body movement and gaze appearing in italics above and below these. These descriptions are placed so as to indicate the time-point in the talk at which they occur.

For brief extracts, the transcript appears only in this volume of the thesis. For longer extracts, several of which are referred to more than once in the thesis, the full transcript appears in Volume 2, with shorter and often simplified sections of these in this volume. This dual system has been chosen so as to allow scrutiny of detailed transcripts, whilst a more 'accessible' transcript accompanies analysis. Where extracts in this volume are labelled 'simplified', this denotes omission or editing of body movement and gaze lines from the transcript, but not of talk lines. Omission of any turns at talk will be indicated specifically.

4.2.1 Conduct in instruction-response sequences where achieving understanding appears relatively unproblematic

The following extracts encompass three types of activity: those in which the therapist physically guides the patient's movement; those in which the therapist observes but does not physically guide; and those in which the therapist performs treatment actions (e.g. mobilisations, manipulations) upon

the patient. The interactional practices by which therapists and patients develop and display mutual understandings about the treatment activity and their participation in it will be described.

For most of the first extract, the therapist physically guides the patient's movement, and the patient effortfully participates, although at the beginning of the extract the therapist is performing movements upon the patient's arm. We will examine the various actions by which the therapist conveys to the patient what he is to do, and by which the patient indicates his responsiveness.

S3Ph4PaMT1/1.41

(Volume 2, pages 1-10)

This patient had his stroke five weeks before the recording, and has been undergoing physiotherapy since then. He has left-sided weakness, with some movement control of his left shoulder and elbow, but none in his hand. The patient lies on his back. The therapist stands at his left side holding his arm (Framegrab 4a)¹³. As the extract begins, an episode of talk concerning the therapists' advice to the patient to rub handcream into his affected hand is coming to an end (the 'something' referred to in line 6 is handcream). Over the course of the extract, an exercise commences in which the therapist

¹³. Parts of the framegrabs have been slightly blurred using the 'blur tool' in Adobe Photoshop to protect identities of the participants. For the same reason, although the original recordings are in colour, framegrabs have been reproduced in monochrome.

raises the patient's arm up perpendicularly, the arm is then pushed further upwards, then moves back downwards again. This involves shoulder girdle movements known as protraction and retraction (Framegrabs 4a and b).



Framegrab 4a (Retraction)



Framegrab 4b (Protraction)

1-90, simplified¹⁴

- 1 T *holding the patient's affected hand
and flexing and extending his elbow
gazes at the patient's face*
T °anyway° () I'm sure your wife's
P *lying on his back on the bed, body appears relaxed
gazing at therapist's face*
- 6 T got something at ho{me hasn't she she can bring in}
P {ooh I'm sure she has yeah }
T yeah
P =I'll get her to bring somethink in
- 14 T *gaze lowers from patient's face to his shoulder
slight grip change of her hands on his arm
(1.5)*
- 17 T *further grip change, starts to raise patient's arm upwards*
T O↓K °hhhhhhhhh

(.)
- 23 T just try and lift your arm up
24 P *body tensing visible,
especially in abdominals and neck,
head pushes back into pillow*
- (3)
30 T sto:p: (.) just relax
P °hh
33 P *tension release*

T °hh

T *raises arm again*
T (7)
P *tenses abdominals and neck as his arm raises*

T any pain with ↑that
P no

¹⁴. Since the simplified transcripts omit whole lines that are present in Volume 2, numbering each line of simplified versions would result in discrepancies between the two versions. Therefore, for the simplified extracts, only turns referred to within the text are numbered, giving the same numbers that appear in Volume 2.

	T	↑no	
50	T	(OK do you want to) try and <u>push</u> up towards the ceiling for me	
51	P		<i>effortful facial expression tenses body</i>
		(1)	
57	T	go on (.) <u>shoulder</u>	
	T	(1) and relax	
65	P	Σhh	
	P	<i>body and face relax</i>	
68	T	<i>shifts body position</i>	
69	T	°hh give you a hand again (1)	
	T		<i>starts protraction, looking down at patient's shoulder</i>
74	T	°hh so your ↑shoulder's actually coming (.) forwards like <u>that</u>	
75	P		<i>tenses, pushes head back, purses mouth</i>
	T	↑yeah	
80	P	Σyeah ((breathy)) (1)	
	T	an again (be so it's a) pushing you <u>lift</u> up	
90	T	that's lovely	

In the first part of the sequence (1-24) there is a transition between activities. Initially, the therapist is mobilising the patient's elbow, his arm muscles are apparently relaxed so that the therapist produces all of the movement and the patient does not show signs of trying to 'join in'. Meanwhile, both parties' talk concerns a topic that is separate from the ongoing arm activity.

It is common for talk on separate topics to occur during activities which therapists perform upon patients (e.g. S2Ph3PaHT3/11.44, this chapter)¹⁵. By line 23, the therapist is moving the patient's arm, but now he appears to actively assist the movement, and henceforth both talk and body movement focus on the same 'topic'. Noticeably, the transition begins through movement rather than talk: at line 14, the therapist leaves eye contact with the patient and looks to his arm. As Heath (1986, Chapter 2) has observed, even minute shifts in gaze are effective in showing preparedness for activity and can function to imply expectations of another's actions. Gaze can also establish the relevance of physical objects - here the patient's arm - for upcoming talk and/or actions (Psathas, 1996).

At the same time as the gaze shift, she changes her grip on his arm. Thus, bodily indications precede the first verbal indications of an upcoming activity change. The first verbal indication is her **O↓K**: a term clinicians recurrently use to initiate and direct topics (Beach, 1995). As she produces this non-specific indication, the therapist's body movements convey more specific information about the forthcoming activity: she places the patient's arm in the posture that forms the starting position for the exercise, then begins the movement (14-17). Thus, by the time the therapist delivers specific verbal instruction (23), the exercise has in a sense already commenced. As this

¹⁵. As throughout this thesis, we make cross-references to extracts that can appear in several locations throughout Volume 1 and also in Volume 2. For this reason, giving page numbers would be very cumbersome. Precise locations can instead be found in the index for the relevant Chapter in Volume 1, and in the index of Volume 2.

instruction is delivered, the patient shows signs of active effortful participation (24). In this sequence, and throughout the extract, the therapist's body movement, touch and gaze play a central part in indicating the site, form, direction, position, timing and pace of the treatment activity. We examine the patient's responses in more detail shortly, but will first consider the format of the therapist's *verbal* instruction.

In her instruction **just try and lift your arm up**, the patient is asked to *try* to do something; its design is sensitive to the possibility that he may fail to achieve the requested movement. This sensitive formulation of instructions is pervasive in the data, and forms an important resource for dealing with the ever-present potential for failures of performance. Soon afterwards (50), there is another example of the patient being asked to *try* rather than to *do* something: **(OK do you want to) try and push up towards the ceiling for me**. This seems even more tentative than her earlier 'just try' formulation. Also, it projects the patient's participation as co-operative and collaborative in that if he complies, this may be taken as indicating that he 'wants to' do the action, and is doing it 'for' the therapist. Conveying notions of co-operative and collaborative participation in therapy through this type of formulation of instructions is recurrent throughout the data.

As well as projecting aspects of the *quality* of participation, therapists' verbal instructions also include information about the *form* of participation by both therapist and patient. We saw that the first specific verbal instruction (23) is taken by the patient as an instruction to actively participate. Another

example is line 30, where precise information is provided to the patient about the activity requested of him: **sto:p: (.) just relax**. Both the words and the tone here convey to the patient what he is to do, and that he is to do so fully and immediately, and he does so (33). At line 57, a brief, encouraging instruction during the activity performance provides specific information to the patient in terms of the body part to which attention is being paid, and on which he is to focus his efforts: **go on (.) shoulder**. Brief, encouraging, specific instructions during the course of performance are also recurrent in the data. Instruction talk can also convey information about the therapist's participation: at line 69, the therapist tells the patient what *her* activity will be during the next movement: °**hh give you a hand again**. Thus, in verbal instructions, information is provided about both general qualities and specific activities that constitute appropriate participation. The body movements that occur alongside, and often prior to verbal instructions provide both elaboration and separate information.

As we turn to the patient's conduct during this sequence, we face a difficulty of analysing recordings of sequences where patients' movements are therapist-assisted: it is not possible to discern accurately the degree of active movement the patient is producing. This could only be discerned by touching the patient or by technical means such as electromyography, neither of which is available to the analyst. Thus there are limitations to our analysis of the patient's participation in this respect. However, what *is* clearly visible in this

extract and others, is the patient's active display¹⁶ of participation (Framegrab 4b, above). Throughout the extract, when guided arm movements are performed, the patient moves other parts of his body too: tensing his abdominal and neck muscles (e.g. 24), and mouth (e.g. 75), and mouthing 'ooh' as if to indicate effort expenditure (141 - Volume 2). He also makes vocalisations that indicate his level of effort (e.g. audible exhalation at 65). Patients regularly convey their participation through tensing body parts and face, and making effort noises. Gaze can also indicate responsiveness: meeting the therapist's gaze whilst instructions are given, and looking intently and continuously at body parts that are the focus of the treatment activity. These displays of effort are of course visible to the therapist. Patients may thus indicate to the therapist something of the quality of their participation, demonstrating that they are active and effortful. Another way in which patients display participation is through the timing of their responses. These are typically prompt: often they initiate movement before the instruction is complete¹⁷ (e.g. 24, 51, 75). Through doing so they display a quality of 'keenness'.

¹⁶. In the previous chapter, we noted that the words design and strategy as used in CA analyses should not be taken as proposing the action is under direct conscious control, rather as implying that it is fitted to some requirement or activity. Likewise the word 'display' is used here to emphasise the way a behaviour makes something (e.g. effortfulness) publicly available.

¹⁷. Notably, in recordings of two patients with whom interaction seemed difficult, and who were described by the therapists as in some way unmotivated, the patients recurrently failed to respond or responded more slowly to therapists' instruction-type actions.

In treatment activities during which patients perform movements *without* therapist assistance, they can demonstrate their participation simply by their independent physical responses (see next extract). However, where treatment activity is performed with physical assistance, as here, the scope for patients to demonstrate their activity level and participation is necessarily more restricted – they are joining in with the therapist rather than initiating movements independently. In this situation, the patient is nevertheless able to demonstrate they are ‘working hard’ through expressions of effort.

Shortly after this extract, there is a sequence that provides evidence that therapists attend to, and make inferences from, patients’ ‘effort displays’. The therapist acknowledges the concentrated participation indicated by this patient’s effort displays, and in doing so, she explicitly indicates her awareness of them:

T you look like yer really
T =concentrat{ing } to do that
P {yeah}

Elsewhere, therapists often acknowledge patients’ efforts non-verbally, e.g. mirroring patients’ facial expressions and effortful exhalations. This mirroring can establish connection and alignment between parties without explicitly referring to it (Heath, 1992b). Across the recordings, therapists often acknowledge patients’ indications of effort. They tend to do so in a way that acknowledges their participation, its difficulties and discomforts, but also conveys that effort is appropriate. This helps to build understanding of the nature of participation expected in therapy.

Thus, during instruction-response sequences, patients can demonstrate their keen participation in therapy, and therapists indicate in various ways what counts as appropriate participation. These sequences also provide opportunities for patients and therapists to display to each other their alignment and mutual understanding about activities. Alignment and understanding are displayed through performance of activities themselves, but can also include verbal confirmations (see lines 74-80).

Besides instructions and responses, assessments of activity performance also contribute to developing understandings about participation. These are regularly produced by therapists, who also solicit them from patients. Less often, patients initiate them. In the next chapter we examine evaluations of performance in detail, therefore we will only comment briefly here by examining the above extract. Glossed positive assessments initiated by the therapist: **that's lovely** (90), **good**. (138) occur both during and after actions. They can serve to acknowledge that something has been achieved (or is about to be achieved), and hence to indicate that moving to the next step in an activity is appropriate (Curley, 1998). More specific evaluations by therapists provide information about what is being assessed and hence what constitutes correct performance, e.g. **shoulder's working nicely there** (192).

Patients also produce comments, reports and evaluations about ongoing activities. Most commonly in the data, and exclusively in this extract, these

follow solicits by the therapist. There is a brief sequence of this sort at lines 43-47. Later, two longer sequences directly topicalise the patient's participation. These sequences represent dialogue about the activity, initiated by the therapist, and occurring after several performances in which the patient did not make comments or ask questions. Thus, as regularly throughout the data, the patient does not produce 'independent' comments or evaluations during a therapist-guided movement. At this stage in the extract, a slightly different exercise has begun (see 115-120): the patient is now encouraged to assist in straightening his elbow, then hold it in position whilst the therapist reduces her support. After several repetitions, the following sequence occurs:

150-164, simplified

- 150 T who was holdin that then me or you d'you think
P =I was at the end
T yeah heh heh
T {{{*laugh*}}}
P {{{*laugh*}}}
164 P well didn't to start with but I was at the end

Thus the therapist explicitly topicalises their respective contributions to the activity's performance. The patient produces a somewhat tentative reply. (The tentativeness with which patients assess their own performance will be explored in the next chapter). After another repetition of the exercise, the therapist asks the patient to report on his subjective experience of the activity:

198-211, simplified

- 198 T how's that ↓feel: >d'you feel that (.)
T it's you that's doing it or d'you

T {feel it's} me
 P {well I }
 P I felt as though was doin a bit towards it
 P any{way}
 211 T {yeah}

Therapists' solicits most commonly concern subjective rather than objective information. We will leave further consideration of solicits and evaluations until the next chapter, and now turn to another instruction-response sequence. As before, the patient performs activities under the therapist's instruction, but unlike the first example, she does not for the most part touch the patient.

S1Ph1PaBT2/11.08

(Volume 2, pages 11-18)

This patient is relatively experienced in physiotherapy, having participated in rehabilitation for seven weeks following a stroke affecting her left side. Early in the session, the therapist introduced the topic of 'things we need to work on' and proposed a treatment goal of independence in standing up from the wheelchair (this sequence - S1Ph1PaBT2/11.04 - is analysed in Chapter 6, Section 6.5). Since this extract is fairly long, we will present a brief description and framegrab illustration of the treatment actions that take place within it and then a transcript of the talk only. We will then examine shorter sections that include body movements.

Two minutes before this extract begins, the therapist says ↑OK °well maybe then we (we) we could do some stand =°h work on yer sitting to

standing. She then makes various preparations. As the extract starts, the therapist has placed a wooden stool in front of the seated patient, and a wheeled one to the patient's left side, with a table to the right. (Framegrab 4c).



Framegrab 4c

As the extract begins, the therapist proposes commencing an exercise of sitting to standing from the bed (13), and that the patient should stretch her clasped hands towards the wooden stool in front of her a couple of times prior to standing (32, and Framegrab 4d).



Framegrab 4d

After adjustment of the patient's position (51-73), another instruction-response sequence of stretching forward occurs (73-104). The therapist then proposes a full stand, which she assists slightly (128) with a hand on the patient's buttock. Over the final part of the extract (104-195), the patient stands up and sits down again twice.

13-195, simplified

- 13 T °h OK then let's look then a:t: sittng to standing as that's
T >gonna be one of our ↓goals
T >the bed's fai:rly ↓low =but °h we want it to be relatively
21 T low so that's similar height to your {wheel}chair
22 P {yeah}
26 T so we'll just see how we {go }
27 P {with } ↑these ({ })
T {yeah}
32 T do a couple of stretches first just reaching forwards
(3.5)
T °might be too far actually°
(4.0)
P and th{en- }
T {and } back again yeah just {just } to
P {mm}
T get {used} to going that far ↓forward
50 P {yes }

Lines omitted in which patient's position is adjusted

- 73 T °h °OK reaching forwards forwards ↑there
(4.0)
T °and back up again°
(2.5)
T °a↑right and again°
(5.0)
92 T ↓that's ↑it and back up >an jus do it one more I'm jus gonna
T watch you from <in front
(0.5)
98 T yeah see how even everything ↑is that looks ↑good
(4.0)
104 T °and back° OK °hh d'you feel then that you could take it from
T there into stand↑ing
107 P yeah
T =O↑K
(0.3)
T alright then
(0.5)
T reachin ↑forwards
(1.5)
128 T o(k)ay >I'll just help you the <↓first ↑time
(2.0)
T and pick yer bottom up ↑there
(0.3)
T and stand up tall (.)
143 T go on you can do it (.) there yer go
(0.3)

T O↑K (.) love↑ly
 P =good
 T =yeah that felt al↑right {there's} no leaning
 P {yes }
 T to me >so that's <good °hh
 T and then do then doing exactly the rev:erse as you go down
 (0.3)
 T >so looking after both ↑arms
 (1.5)
 T that's ↑i:{t: }
 P {yes}
 T and slowly bending bending both yer kne:es:
 (0.3)
 T control it control it
 (7.0)
 P (and ↑down)
 195 T =yeah and sit down yeah

Many features identified in the previous extract are apparent. We outline these, then move on to features that differ. As in the first extract, the therapist prepares the treatment environment prior to producing specific instructions; such position changes and large-scale body movements often display boundaries between segments of interactions (Jordan and Henderson, 1995). Furthermore, it has been found that across settings, body movements regularly preface related verbal actions (Heath, 1986, 1992b; Jordan and Henderson, 1995). Other features common to both this extract and the previous one follow.

In the therapist's verbal instructions we see tentative formulations:

**so we'll just see how we {go } do a couple of stretches first
 just reaching forwards (26, 32)**

and instructions that include specific information about the therapist's participation:

I'm jus gonna watch you from <in front (92).

There are shorter utterances that seem designed to encourage and project effortful patient participation, and that mark successful achievement of the activity:

go on you can do it (.) there yer go (143).

The therapist provides talk that indicates achievement and gives specific information about how performance is being judged:

**I'm jus gonna watch you from <in front yeah see how even
everything ↑is that looks ↑good (92, 98)**

and she solicits information from the patient about subjective aspects of participation:

**d'you feel then that you could take it from there into stan↑ding
(104).**

Aspects of the patient's responses also show similar patterns to the previous extract. She shows alignment with the therapist's proposals and evaluations, sometimes through her talk as in the following exchange:

**104 T d'you feel then that you could take it from there into stan↑ding
107 P yeah**

but predominantly through physical responses: she complies with each instruction, and displays keenness to participate correctly via her responsiveness. For instance, when the therapist produces a corrective instruction about a movement in progress (170), the patient's movement and her facial expression convey the nature of her response (174):

165-177, simplified

165 T and then do then doing exactly the rev:erse as you go down
166 P *starts to bend*
at hips

(0.3)

170 T >so looking after both ↑arms
P *descending, affected hand and arm dangling*

(1.5)

174 P *at 0.5, suddenly opens mouth and makes a very rapid movement*
of unaffected hand to catch hold of wrist of affected arm

177 T that's ↑i:{t: }

The patient's response to the therapist's instruction utterance **>so looking after both ↑arms** (170) is somewhat delayed, perhaps because she does not initially grasp what is being asked, or because the action requires additional balance work. When she does respond, she does so rapidly, and with a facial gesture that powerfully conveys awareness and realisation of her 'error'. The initial lines of this sequence (165-6) show a patient response similar to those examined in the previous extract: the patient complies with the therapist's instruction during the course of its production, in overlap with it, i.e., promptly (see also 73-83).

We now move on to examine the additional resources by which this patient and therapist develop and display understandings about treatment activities. The patient shows keenness to participate through actions not seen in the previous extract. One striking aspect is that, in contrast to the first extract, this patient recurrently solicits verbal information from the therapist about the

activity and its timing. In the following sequence the patient's solicit is a brief glance to the therapist:

79-85, simplified

- 79** **T** °and back up again°
 P *starts to move upwards*
- 83** **P** (2.5)
 glances to therapist's face once upright
- 85** **T** °a↑right and again°

In recordings of this patient's treatment, she can be seen repeatedly to perform such glances, and occasionally verbal actions (see below), at similar junctures. These recurrently result in therapist conduct of the type seen in the sequence above, i.e. talk that indicates to the patient what is expected next. That is, these glances and verbal actions can be seen to function as subtle 'checks' by the patient that her performance was correct. In the sequence above, her glance (83) conveys the patient's interest in the therapist's view, and may prompt the therapist's next instruction¹⁸. Examples of the patient verbally soliciting information from the therapist can be seen at line 27 and also in the following sequence:

181-198, simplified

- 181** **T** and slowly bending bending both yer kne:es:
 (0.3)
 T control it control it
 (7.0)

¹⁸. In training situations, next instructions regularly indicate that a prior action was completed satisfactorily (McHoul, 1985; Curley, 1998).

- P** *descends, but hesitant and
does not descend all the way to sitting*
- P** (and ↑down)
- 195** **T** =yeah and sit down yeah
 (0.8)
- 198** **P** *bottom reaches bed*

The patient's glances and verbal solicits thus appear to form effective resources for seeking information and achieving understandings about the correct activity, and what is to come next. We did not see the patient in the previous extract seeking information in this way. There, the patient's movement was guided, and it was argued that this restricted his participation because he followed rather than instigated movements. In this extract, the patient is able to display more 'full' participation by initiating and accomplishing movements by herself. However, as the above sequence illustrates, when activities are performed independently of physical guidance, other challenges for achieving and displaying appropriate participation arise. When the therapist's hands are not in contact with the patient, an information source is lost and the patient uses different means to determine appropriate movement participation.

We now turn to certain features of this therapist's conduct. For most of the sequence, she is not touching the patient; other means are used to communicate the nature of her own participation and that required of the patient. These include gestures that elaborate and emphasise the sense of her talk (e.g. line 53 – Volume 2, and Framegrab 4c, which is reprinted overleaf).



Framegrab 4c, note therapist's gesture

The therapist is also free to move around in the treatment space in a way not possible when continuous physical contact is required. For instance in lines 91-98 (Volume 2), the therapist moves on her wheeled stool so that she is in a position to watch the patient from in front, allowing her to **see how even everything ↑is** (98). The spatial repositioning takes place within the patient's field of vision, and indeed the patient looks at the therapist (93) (Framegrab 4e, overleaf). The therapist moves some distance away and clearly would not be able to offer physical assistance without further position change. Thus, her posture and spatial position, and changes in these, form a resource by which the therapist indicates to the patient her part in the activity.



Framegrab 4e

Another resource by which this therapist works to develop mutual understanding and to encourage participation is the incorporation of reasons for performing an activity within instructions: **OK then let's look then a:t: si:tting to standing as that's >gonna be one of our ↓goals(13).** In Chapter 6, we will examine talk about reasons underlying activities, including its role in motivating patients' participation.

Besides talk, touch and gesture, a further resource therapists often use in developing understanding about the nature and methods of treatment activities is physical demonstration, sometimes described as modelling (Talvitie, 1996). Another extract illustrates this additional aspect of therapists' instructional body movements.

(Volume 2, pages 19-33)

This extract will be examined several times in the thesis. It involves a patient who had a relatively mild left-sided stroke sixteen days before. Examination and treatment of his arm and hand have been the primary concern of the session so far. During the full extract, a series of treatment activities involve the patient attempting to manipulate various objects in his affected hand. Problems and failures of performance are apparent, and their management will be analysed in the next chapter. Here we examine the therapist's initial instructions and the patient's initial attempts to manipulate the first object: a beanbag. As the sequence begins, the therapist returns to the treatment area having fetched an item for the patient to manipulate. The patient is sitting on the treatment bed.

18-37

- 18 T *picks up beanbag, walks in front of patient
as she does so she looks down and turns beanbag over
in her hand*
- 19 *patient's view of beanbag is blocked by the therapist's body
(8)*
- 21 T *is now in front of patient,
holds beanbag out in front of his face and sits down
holding beanbag in left hand
looks down at it
'weighing' gesture of beanbag*
- 22 T O↑K just 'ave a ↑go at (.) turning this (.)
- 23 P *looks at beanbag*
- 25 T *passes it to her right hand*
- 26 T just hold it in yer hand for me {(patient name)}
- P {yeah }
- T *starts to turn it one-handed using fingers and thumb
her hand is across her body so it is positioned towards patient*
- 31 T I want you just to turn it over =
- P = turn it over yes

T *has completed two turns and reaches it towards patient*
T yeah {OK }
P {yeah}
37 *P* *reaches out for it with both hands*

The first movement of the beanbag that the therapist can be seen to perform is not a demonstration, at least, not for the patient – it is not in his field of vision (18) (Framegrab 4f, below). It appears that the therapist is exploring the possibilities of activities with the bag.



Framegrab 4f

At line 21 she is holding the beanbag in front of the patient, who clearly attends to it with his gaze (23). She does a small 'weighing' movement of her hand, so that the beanbag moves up and down slightly. This seems to be an 'emphasising' or 'stressing' gesture (Schegloff, 1984; Heath, 1992b), it is used several times over the whole sequence. The gesture forms part of the demonstration in that it illustrates and emphasises the position of the beanbag, elaborating her talk at line 26. This is another example of the regular pattern wherein a body movement precedes and is informative about a verbal instruction (see above, and Heath, 1986, 1992b; Jordan and Henderson, 1995). Before demonstrating the actual turning movement, the therapist moves the beanbag into her other hand (25). As a result, her rolling movement will be performed in the hand that corresponds to the patient's affected hand, and therefore with the same directional orientation with which he will perform the activity. She then demonstrates the turning movement (Framegrab 4g, overleaf) before moving the bag toward the patient, who takes it from her.



Framegrab 4g

As the patient takes the bag, the therapist rapidly places her hands in her lap, and straightens her posture so she is no longer leaning towards him. As in the previous extract, the therapist's spatial withdrawal conveys information about her participation, indicating that her current activity is observing the patient rather than 'hovering' ready to intervene and physically guide.

However, the patient makes errors both in positioning the beanbag (44-50, below), and then in the actual turning activity (52 onwards). The management of these failures is dealt with comprehensively in the next chapter; here we focus on the therapist's physical actions. When the patient positions the beanbag erroneously, the therapist's verbal response to this error is oblique (see 47). But her body movements are explicitly corrective (46) (Framegrab 4h, overleaf).



Framegrab 4h

44-48

- 44 P like that
P has positioned beanbag with long edge along his hand rather than across his palm
- 46 T rapidly reaches left hand across towards beanbag, and leans in towards patient
moves beanbag so long edge is across patient's palm
(Framegrab 4h)
- 47 T well (.) { yeah sidew }
48 P {or like that sorry}

Thus, the therapist avoids direct verbal reference to and confirmation of the patient's initial positioning error, whilst at the same time using physical means to attend to and correct it.

The patient now attempts to turn the beanbag, but executes a different movement to that which was demonstrated (Framegrabs 4i, 4j).



Framegrab 4i



Framegrab 4j

This time, both the therapist's talk and her body movement deal with the problem directly:

52-66, simplified

- 52 P turns beanbag over by pronating forearm
(1.5)
- 56 T leans in toward patient
holds her right hand out and moves fingers and thumb
in a rolling motion. Looks at her hand
(Framegrab 4k, below)
- T >no no just turning it over
- 58 P brings his right hand towards beanbag
((no apparent moves to do the rolling action))
looks to therapist's hand
- T reaches to take hold of beanbag
(Framegrab 4l, below)
- P over
- P has brought own right hand onto beanbag
- T takes beanbag and places it flat in her left hand
- T let me show you again
- 66 P gaze follows therapist's hands



Framegrab 4k



Framegrab 4l

Here then, the therapist initially demonstrates the correct movement without actually holding the beanbag (Framegrab 4k), but then ‘upgrades’ the demonstration by taking the beanbag itself (in Framegrab 4l the therapist is taking hold of the beanbag ready to demonstrate with it). This may be because the patient’s movements at line 58 do not suggest that he is about to perform the correct form of movement. It is not possible to offer a definite explanation for why she performs this ‘full’ demonstration’ here. However, there is evidence in other sessions that therapists use demonstrations at times when verbal and tactile clues to the patient have proved unsuccessful in achieving the movement the therapist evidently intends. Subsequently (see Volume 2), the therapist demonstrates the movement again (75) as the patient watches. The demonstrations serve to provide an evocative and effective way of instructing a patient in a novel and complex movement. Their functioning is facilitated by the spatial configuration of therapist and patient which allow both to see the activity, and allow rapid interchange between therapist demonstration and patient attempts. This spatial configuration seems an important factor: consistent with these data, Talvitie (1996) found therapists used demonstrations when patients were sitting and standing, but not lying.

When we return to this sequence in Chapter 5, we will see that the demonstration does not meet with great success: the patient *attempts* but cannot *accomplish* the ‘right’ movement. However, in many other sessions, demonstrations are successful in that they are followed by patients’ achievement of the demonstrated movement.

Extracts so far have mainly illustrated two forms of activity: those guided by therapists' physical assistance, and those performed by the patient under instruction, without physical assistance. One further form of treatment activity entails actions performed upon parts of the patient's body with which the patient does not 'join in' through muscular efforts. This is seen in the next extract.

S1Ph2PaHT3/11.44

(Volume 2, pages 34-39)

This extract occurs earlier in the session in which the beanbag sequence arises. As the session starts, talk and physical examination concern the patient's affected left arm. Actions then change to a recognisable physiotherapy treatment activity: mobilising the patient's finger and thumb joints.

As we enter the extract, the therapist has just finished moving the patient's unaffected right hand, whilst he sat upright, looking forwards and to the middle-distance, and evidently allowing the therapist to move his arm (Framegrab 4m)



Framegrab 4m

17-37, *simplified*

- 17 T ri:ght ↑OK:
- T *moves to patient's left side*
picks up patient's left, affected hand
- 21 T just seein' how they work on that side
- T *looks at back of patient's shoulder*
takes hold of patient's left elbow
raising his left arm
- 24 T comp{ared to} (.) what's happening on this side
P {yes }
- T *lowers patient's arm*
P Σ°mm
- 29 P *looks forward and down, middle-distance*
- T *climbs onto bed and moves behind patient*
raising and lowering patient's arm
then changes grip, palpates left biceps and elbow
(15)
- 33 P *looking forward, middle-distance,*
looks briefly down towards his arm when therapist changes grip

T *moves hands so both are on patient's affected hand and wrist*
 glances up to him
36 T °h so where does it (.) fee:| stiff
37 P *rapid, large amplitude head turn towards*
 his affected arm
 starts to reach over with
 his right hand

Fairly unusually for these data, the therapist provides an account for a recently performed activity— moving the patient’s right, unaffected hand (21, 24). It may be that she does so because attention to the unaffected side in therapy could be puzzling for the patient (*c.f.* S3Ph5PaNT2/2.25 in Chapter 6). As the therapist begins to examine his affected arm, the patient for the most part gazes into the middle-distance and downwards, and maintains a silent and slightly detached-looking demeanour (29,33, and Framegrab 4n, overleaf). This pose is typical of patients undergoing physical examinations by clinicians (Heath, 1986, Chapter 5). Heath argues that through these practices, the patient frees the clinician from any interactional obligations that would result from gaze or talk directed towards them, and that they thereby avoid disrupting the clinician’s actions. At the same time, he notes that patients are only “seemingly uninvolved” (p102): that in fact they closely monitor clinicians’ activities, and are highly responsive to their actions. We see this in the sequence above where the seemingly passive patient glances towards the action when the therapist changes her grips (33), and is immediately verbally and physically responsive to her question at line 36 (Framegrab 4o, overleaf).



Framegrab 4n



Framegrab 4o

Notably in this extract during the part of the examination concerning the affected arm (after line 29), and in others involving treatment activities performed upon patients' bodies by therapists, the patient does not make 'effort displays', nor does he solicit information about the activity. In avoiding these, the patient displays a 'passive' form of participation that avoids demanding any interactional response from the therapist (Heath, 1986, Chapter 5; Pilnick and Hindmarsh, 1999).

In order to further analyse conduct during activities 'performed upon' patients, we now examine the transition from examination to treatment activity that occurs a short while later in this extract. During the arm examination, the therapist adopts a series of different positions and postures as she moves the patient's arm. As questions and answers pertaining to the examination come to an end with a pause (75) and a summarising/confirming comment from the therapist (78), the therapist begins mobilising the finger and thumb joints of the patient's affected hand. In contrast to examination actions, she continues this activity for several minutes.

74-102, simplified

74	T	<i>adjusts grip on patient's hand</i>
75		<i>(0.5)</i>
78	T T P	<i>mobilisations¹⁹ of patient's finger and thumb joints start mainly the <u>hand</u> looks down to his left hand and the therapist</i>

¹⁹ Mobilisations are a therapeutic technique in which patients' joints and/or muscles are passively moved by the therapist in order to improve their flexibility.

- 81 T *climbs off bed and sits down on it*
continues the mobilisations of his thumb joints as she moves
(2)
- 83 P *maintains gaze down and forwards*
- 85 T °hh it's still a little bit swollen in't it- >ave you been doin that
T massa:ge that we suggested
P ye:s yes
- T *mobilising patient's thumb*
(1.5)
- P I've been doin the finger exercise an that
T yeah
- T *mobilising fingers*
turns head to look at patient
- 102 T 'ave the OTs seen ↑you

The patient now adopts a position which he too maintains for some time: his trunk is rather flexed, and he looks downwards rather than towards his affected hand which the therapist is treating; his arm is 'left' in the therapist's hands (Framegrab 4p).



Framegrab 4p

In this treatment activity sequence, the therapist continues one repetitive activity for some time. This differs from the series of sequential activities typical in examinations (Heath, 1986, Chapter 5). It is also different in that the therapist provides no commentary or explanation about what she is doing, and instead introduces talk on distinct topics: whether the patient has been doing a massage exercise (85), and whether he has seen the occupational therapists (102). The separation of talk and body movement 'topics' is one way in which these treatments performed on patients differ from examinations (as well as from most other treatment activities in which patients' participation is more 'active'). Like the doctors Heath examined, therapists tend to talk very little during examinations, and if they do, the talk is about the object and processes of the examination. In contrast, talk on a separate topic is common during mobilisations etc. There may be practical reasons for this – the repetitive, passive nature of the activities may require less concentration on bodily activity by both therapist and patient than during examination, thus allowing for talk on other topics. Usually, though not invariably, the topic is treatment-related in some way; this may reflect an 'efficient' use of available therapy time. Furthermore, there may be interactional reasons for introducing verbal topics during these procedures. Medical situations where technical procedures are conducted on a patient's body entail a delicate balancing of the demands of interacting with the patient as both person and object (Pilnick and Hindmarsh, 1999). Talk on separate topics during 'passive' treatments may form one way of dealing with these.

4.2.1.1 Developing understandings in instruction-response sequences: summary

In order to accomplish physiotherapy, patients and therapists need a mutual understanding of the methods and participation required for performance of treatment activities. The basic resources by which therapists develop these understandings include: verbal instructions and evaluations, gestures, touch and physical guidance, spatial position changes, and demonstrations.

Patients contribute to understandings through the nature and quality of their physical responses, and through their talk. Patients' talk, when it occurs, is usually brief and consists of seeking elaboration or reassurance about what is being directed, or responses to therapists' solicits. In these data, patients very rarely question or resist instructions.

We have described three broad modes of participation in physical treatment activities. In these different modes, constraints upon and resources for development of understanding vary. Sources of information about the form and timing of actions differ depending on whether the therapist is physically guiding patients' movements or not. When the therapist is not in physical contact, additional information about such things as the direction and timing of actions is conveyed through therapists' talk, and may be solicited by patients. Another aspect that differs depending on the form of activity is the patient's level of involvement and participation. Most obviously, their physical contribution to movements, and particularly the instigation of movements is reduced during guided activities, and is minimal in activities which the therapist performs upon them. Where actions are performed on patients,

effort displays are rarely seen, and their participation consists of rendering the body or body part available and 'pliable' for treatment by the therapist. This contrasts with the "keen" and active participation seen during other activities. The most 'active' level of participation is evident during activities wherein the therapist is not touching the patient. When the therapist is physically guiding a patient, initiation of response by the patient is constrained because of the requirement for the patient to follow the therapist's movements. In an extract to follow shortly, we will see that the demands of following the therapist's lead can conflict with the production of keen and rapid responses.

It is rare for patients to ask direct questions about the overall form and nature of a treatment activity²⁰. It is also fairly rare for them to provide evaluations or comments about performance of the activity, unless these are solicited (and even then, they may be reluctant to evaluate, see Chapter 5, Section 5.7). When patients *do* initiate evaluations, in general this only occurs during activities which are not physically guided or performed by the therapist.

²⁰. Although there is no space to present examples, there are striking instances in the data where patients *do* ask direct questions about therapy-related activities. These concern activities to be performed outside the sessions. Therapists only rarely volunteer this information unsought, but there are several episodes in which they provide it in response to patients' direct questions.

The general pattern throughout extracts examined so far in this chapter, and overwhelmingly within the data, is that therapists lead and orchestrate the treatment activities, and patients respond, follow, comply and show willing participation. This conduct reflects an orientation to the therapists' authority, and to keen and compliant conduct by patients. Further examples will now highlight these orientations.

4.2.1.2 Extracts illustrating patients' and therapists' orientations to therapists' authority

The following extract provides further illustration of the way that patients orient to therapists' authority to lead and orchestrate treatment activities. Towards the end of the treatment session which involved the beanbag, the therapist has proposed practising writing, and brings the necessary equipment into the treatment area, setting a table and paper in front of the patient, who is already holding the pencil in his left (affected) hand. He makes an initial movement towards the paper. However, he does not commence writing until specifically directed to by the therapist. This is reminiscent of the hesitancy seen in the actions of Patient B as she sought the therapist's direction whilst practising rising from and descending to the treatment bed (S1Ph1PaBT2/11.08, this chapter). Both patients seem to wait for some word or explicit sign from the therapist before instigating actions, even though general instructions have been given.

S2Ph3PaHT3/12.03

- 1 T *therapist comes into camera-view with
a piece of paper in her hand, moves a table,
puts paper on table*
- 2 (34)
- 3 P *as therapist puts paper down, patient looks towards it
and reaches towards table edge as if to pull table towards him*
- 4
- 5 T *moves towards patient's left side*
- 6 T *tha(t)'s ↑it*
- 7 P *lowers his right hand and hitches body
nearer edge of treatment bed*
- 8
- 9 (4)
- 10 P *briefly reaches and adjusts paper with right hand*
- 11
- 12 T *is now sitting down*
- 13 T 'K: (.) want to 'ave a ↑go
- 14
- 15 T at ↑writing some↑thing (.) or: just
- 16 P *raises right hand to the paper, then places left hand, which holds
the pencil, onto the paper*
- 17
- 18 T do yer (.) yer signature or wha'ever ...

Thus although the patient seems to make some moves towards the table and paper (3, 7, 10), and although writing has been clearly proposed as a next activity (prior to this transcript), the patient does not initiate writing until the therapist gives a clear instruction (13-15). In this and the previous extracts, the patient shows an orientation to responding to the therapist, rather than initiating activity by himself.

Very occasionally, in contrast to the extracts above, patients do 'take the lead': commencing movements which are apparently neither expected nor directed by the therapist. For instance, on three occasions (not shown due to

restrictions of space) patients begin to move from a sitting to a lying position. Therapists halt this through verbal and physical actions, and verbally sanction the patient, although in a jokey or gentle manner. A similar pattern is seen in the following sequence, which features a patient initiating an activity. On this occasion though, there is some prior instruction, but it becomes apparent that the therapist's instructions and guidance are incomplete. The patient's keen, prompt commencement of activity means he acts without wholly following the therapist's directive. The extract shows it can be difficult for a patient to balance the demands of conveying keen participation with the demands of aligning and displaying an orientation to the leading role of the therapist. This can result in loss of alignment and disruption of participation. The extract also illustrates that misunderstandings about the nature of participation in a treatment activity receive immediate attention and repair.

S3Ph4PaMT1/2.09

(Volume 2, pages 40-43)

Three minutes before the following sequence, the patient performed a repetitive exercise which involved sliding his affected hand forward on a table with physical guidance from the therapist. No specific verbal instructions were given at this time, the therapist's directions were tactile. During his performances, the patient flexed his body slightly as his arm slid forwards. The therapist then asked the patient to stop the activity. We enter the extract after a short interlude of leg exercises.

1-17, simplified

- 1 T *hand is on patient's left hand.*
T al:ri:ght >are you happy standing ↑there
P ↑yeah yeah yeah
- T *moves closer to the patient's side,
places her right hand behind his left elbow,
left hand remains over patient's left hand*
- T OK
(2)
- 11 T what about just
(4)
*Patient immediately starts to flex trunk, his left elbow flexes
then hand starts to push forward a little, with a judder
Therapist looks downwards, then turns head towards
him and smiles soon after his hand movement has begun
As therapist looks and smiles, patient stands straighter
and draws arm back
patient is looking down at hand throughout*
- 17 T \$I hadn' even ↑said ↓then\$

Through the position of her hands on the patient's arm, the therapist seems to imply and project an activity similar to the previous arm exercise. She produces a vague and incomplete instruction: **what about just** (11). The patient immediately begins to perform the same arm movement he had done before, his arm sliding forwards and his trunk flexing slightly. Thus, we see a prompt, 'keen' response to the therapist's instruction. However, the patient's action is immediately marked as problematic by the therapist: **\$I hadn' even ↑said ↓then\$** (17). As the sequence progresses, it becomes clear that the therapist had intended a slightly different activity this time:

26-42, simplified

- 26 T right >I want to try and mo:ve ye- arm (0.2) and at the moment
T you're actually <using sor- of just moving yer body
P yeah
T °h to move your arm
P mm
T OK so if you ↑let me ↓do it (.) >I just want to <↑feel what it's like
42 P °uh huh°
... *Therapist goes on to guide patient's arm forwards*

The misunderstanding seems to arise as a result of a mistaken expectation on the part of the patient that a foregoing exercise is to be precisely repeated. The therapist's initial instruction seems to contribute to the misunderstanding, especially in the context of the prior activity. Vague, unfinished instructions are not unusual, and often patients 'get it right' in response to them. There can be good reasons for an incomplete instruction, as we will see in the next chapter (Section 5.4.5), however in this extract it seems to contribute to misunderstanding. Despite the initial misunderstanding, both parties show orientation to the therapist's authority in that the movement the therapist 'wanted' that is treated by both parties as the correct one, and is subsequently performed. Thus, by the end of this sequence, alignment and co-participation are restored.

The orientations to the differing roles and actions of therapist and patient illustrated in all the above examples are pervasive throughout the data. However, orientation to the therapist's authority to determine what is done in treatment is not cast in stone, and patients' comments and responses do influence the agenda of treatment. We will see some clear examples of this when we examine goal-setting (Chapter 6).

4.2.2 Managing lack of understanding and misunderstandings

The previous extract illustrated the immediate attention and repair that a patient's misunderstanding receives. Such misunderstandings are uncommon in the data, but because they are so informative with respect to how parties orient to understandings in this area, we will examine one more example. This time, it is the patient who makes her lack of understanding apparent, and who seeks its repair.

S4Ph10PaRT3/10.24

(Volume 2, pages 44-52)

This patient's stroke occurred 25 days before and has mainly affected her right leg and her balance. One minute before the start of the extract, the therapist finished a lengthy examination of the patient. He then said: **we'll do some (.) little bit of balance work in standing**, and the patient nodded. The therapist goes on to tell the assistant what she is to do during the standing practice. The patient sits on the treatment bed, the assistant to her left and the therapist in front, sitting on a stool and holding the patient's hands (Framegrab 4q, overleaf). Prior to this extract, the general character of their interaction has seemed 'jokey' or light-hearted; previous activities have involved many verbal instructions and appear to have been performed smoothly and co-operatively. This next activity seems more problematic. The body movement description in this transcript is quite complex, see Volume 2.



Framegrab 4q

2-19, *simplified*

- 2 T right O↓K
(2)
T jus gent{↑ly}
11 P {d'}you want me to s:- s:-
(3)
19 T °just follow my ↑hands°

Throughout the extract, the therapist repeatedly draws the patient's hands and arms forwards (Framegrab 4q). At a brief pause in the movements, soon after they have begun, the patient says **d'you want me to s:- s:-** (11). In the context of the therapist's recent utterance about practising balance in standing, it seems likely that she is asking, albeit hesitantly, whether he

wants her to stand up. He does not speak and continues the movements, while the patient's facial expression and head-shaking seem to indicate some exasperation (line 16 - Volume 2, and Framegrab 4q). After a pause, the therapist responds but does not directly address whether the patient is to stand or not: °**just follow my ↑hands**° (19)²¹. The forward and back movements led by the therapist continue, about 6 seconds later the therapist says °**jus wanna see how you ↑move**° (35). The movements then continue largely in silence. At one point (59 – Volume 2), the therapist holds the arms out for longer, moves his head and shifts his gaze to one of the patient's knees. As his head and gaze return to a more central position, the patient follows with her gaze, then asks a further question (64, below). That is, she once again takes the opportunity of some change in the therapist's activity to produce a turn at talk, as is typical of the timing of patients' utterances and their avoidance of disrupting clinicians' activities (Greatbatch et al., 1995; Heath, 1986).

64-90, simplified

- 64 P** ↑what am I tryin to ↓do:
(0.5)
- 72 T** °well° (.) ↑you just follow my ↑hands hah hah hah hah hah (.)
T I'm de↑liberately not (.) ↑telling you
- 76 P** °mm hm°
(1)
- 86 T** hah hah >which is very frustrating in' it
- 90 P** =absolutely

²¹. A procedure sometimes performed in physiotherapy is to draw a patient's hands forwards so far that they end up moving into a standing position. Whilst it is not possible to discern this therapist's intentions, it may be that he is attempting to do so.

In contrast to the patient's earlier question, her question at line 64 concerns what *she* is to do, rather than what the therapist is doing. The therapist responds a little sooner, and acknowledges that he is not being explicit about the activity: °well° (.) ↑**you just follow my ↑hands hah hah hah hah hah** (.) **I'm de↑liberately not** (.) ↑**telling you** (72-6). He acknowledges the patient's feelings through laughter and further talk: **which is very frustrating in' it** (86). He then reproduces and elaborates slightly on his explanation of the activity: °hh **I just wanna see how you ↑move (0.3) what you're (0.2)** °hh ↑**tending to ↓do** °hh (we-) (98-105 - Volume 2), although as before, this gives little information to the patient about what *she* is to do. Soon after this, the activity changes to one of examining the patient's hips and back.

In summary, as in the previous extract, the misunderstanding seems associated with ambiguity of instructions, and with a context in which the patient may have expected a certain type of action. The patient almost immediately orients to displaying her lack of understanding, and to seeking to rectify it through talk, gaze and facial expressions which convey affect: her face indicates frustration and unhappiness. She thereby conveys an expectation that the therapist should provide her with this information. He provides an account, albeit rather insubstantial, for not adequately conveying the nature of the activity, also he laughs – seemingly in recognition of the oddity of the situation. Thus, both patient's and therapist's conduct shows they orient to establishing understanding about the nature of a treatment activity as something which is expected and usual. Finally, it should be emphasised again that misunderstandings of this sort are uncommon in the

data because usually therapists and patients work to align and establish mutual understanding.

4.3 Summary of interactional practices and patterns

Therapists initiate and direct activities, in doing so they convey to patients the nature of therapy activities, and of the expected participation. Patients respond to therapists' directions, typically in a manner that is unquestioning, that indicates keen co-operation, effortful participation, and a desire to perform 'correctly'. Patients display a concern to show their participation as conscious, deliberate and keen²².

The extracts illustrated that physiotherapists and patients use body movements to communicate multiple elements of their activity, both alongside and distinct from talk. Their body movements, particularly in the way they foreshadow and project forthcoming actions, are central to the sustained, intimate co-ordination of interaction in physiotherapy. Furthermore, they convey rich information about the form and quality of the parties' participation, including orientation to leadership and authority, compliance and motivation, and alignment in collaborative physical activities (Kendon, 1979; Jordan and Henderson, 1995). Certain characteristics of body movements and the way

²². In contrast, 'difficult patients', to whom the label 'unmotivated' tends to be ascribed, often appear to respond very slowly to instructions, for instance, sitting still until very directly prompted. Generally, they show less effort in terms of physical activity, and display less verbal and physical alignment with therapists.

they can function in interaction make them especially significant resources in physiotherapy. Gesture, touch, demonstration and other bodily displays have special capacities for communicating physical, spatial and embodied ideas and activities (Kendon, 1985, Argyle, 1988, Heath, 1992b). In addition, body movements can form a particularly subtle, tentative and potentially ambiguous interactional resource (Goffman, 1983; Heath, 1986, Chapter 2); they have the capacity to be less precise in their meaning than talk (Schegloff, 1984). In addition, they are not (in most circumstances) oriented to as obliging response from their recipient in the way verbal actions generally are (Kendon, 1985). For these reasons, body movement is "often adopted as a medium of utterance where the utterer seeks to be less fully bound or officially committed to what he or she has to say"; where "speech might be regarded as too explicit or indelicate" (Kendon, 1985, p223). Therefore, as illustrated in this chapter, body movements are a well-suited resource for patients to communicate with therapists without interrupting them or obliging their response. They thus form a resource by which patients maintain an orientation to the therapist's authority to direct the actions without disturbance. The next chapter (especially Section 5.4.1) illustrates that therapists also use this delicate, tentative quality of body movement in the way they deal with patients' failures and mistakes.

We will now expand our analysis by relating the practices we have described to previous sociological descriptions and explications of conduct.

4.4 *Some sociological insights into patients' and healthcare professionals' conduct*

Having considered aspects of the physical form of physiotherapist patient interactions, we now turn to issues concerning the orientations and conventions that underlie them. To do so, we turn to the work of two sociologists: Parsons (1951, 1975) and Goffman (1969, 1981b), both of whom described and analysed the interactional conduct of people with physical incompetence and of those who treat them. Parsons' writings on patients' and doctors' conduct, and his model of the sick role and patient role²³ have been highly influential in the development of sociological understandings of the conduct of ill people and of healthcare agents. We therefore begin by outlining his model and examining its relevance to our analysis of patients' and physiotherapists' interactional conduct.

Parsons' central interest was in how societies come to be ordered and stable. Thus one of his concerns lay in understanding how conduct that is disruptive or potentially disruptive to social order is managed within society. Illness is one such form of conduct because a social system needs healthy people if it

²³. Parsons (1951, p476) defines the sick role as pertaining to all of the ill person's social activities, whereas the patient role particularly concerns being a recipient of a healthcare professional's services. In this discussion, the term sick role is used to encompass both elements.

is to function²⁴. As we mentioned in Chapter 3 (Section 3.3), he views social organisation as resting upon internalised norms which determine people's conduct.

Parsons notes the 'special treatment' ill people receive within society: they are exempted from certain responsibilities and obligations (e.g. going to work) and are generally treated as deserving therapeutic assistance rather than condemnation and punishment. He argues that the permissiveness afforded to ill people is dependent on their showing acceptance of certain responsibilities. The sick role thus constitutes a configuration of exemptions and responsibilities (Parsons, 1951, 1975), which he outlines as:

- An assertion and acceptance that the state of illness is not the fault of the sick person and is hence beyond his or her control. The person is thus not expected to get well through their own decision or will.
- An exemption from ordinary, everyday obligations and expectations.
- An expectation (dependent on the severity of illness) that the person will seek assistance from some form of institutionalised healthcare agency.

Seeking this help "further includes the admission that being sick is undesirable and that measures should be taken to maximize the chances to facilitate recovery or, if the condition is chronic, ... to subject it to proper "management"" (Parsons, 1975, p262).

²⁴. If the benefits of illness (rest, relief from obligations including the obligation to productive work) were to outweigh pressures not to be ill, the long term result would be that society become unable to self-sustain (Dingwall, 1976).

Being exempted from certain responsibilities and receiving therapeutic assistance is thus contingent upon judgements (by others, including healthcare agents) that the person's claim to illness is legitimate, that they do not want to be ill, and that they co-operate with efforts to alleviate it. In doing so, they show a commitment and allegiance to social stability and order.

Likewise, Parsons explicated the way that healthcare professionals' roles and actions entail a balance between permissions or rights, and responsibilities. They are recognised as certified experts who are entrusted with responsibility and authority in matters of health and illness. Balancing this authority and trust is an obligation that they do all they can to assist the patient and alleviate their condition. Also, that they afford understanding, support and encouragement to patients. As we noted, this is contingent on patients' co-operative efforts. Parsons also proposed that healthcare agents form a vital element of social mechanisms for maintaining order. For him, doctors, therapists and other healthcare agents are "reintegrative forces" (Parsons, 1951, p313) whose activities contribute to social orderliness.

Applying these understandings to physiotherapist patient interactions, the patient is expected to do their best and to co-operate with therapeutic efforts; and in doing so to grant and accept the therapist's authority. At the same time, the physiotherapist is obliged to assist and motivate the patient in the direction of 'getting better', and to do so in a manner that conveys support and understanding. Furthermore, Parsons' analysis exposes the significance of physiotherapists' interpretations of patients' conduct. Specifically, in order

to be supported, accepted and treated, patients need to provide evidence that they are genuinely disabled, and that their disability is unmotivated, i.e. not their fault nor something they could alleviate by themselves. Likewise, they need to show co-operation with the therapist in working towards alleviation of disability. Thus, in physiotherapy sessions, patients need to show that failures of physical competence are not just the result of failure to make sufficient efforts, but are 'genuine' disabilities. In this chapter, these orientations to displaying both the genuineness of physical disabilities and of efforts to alleviate them are manifested in patients' displays of effort, of keen participation, and of their desire to 'get it right'.

Therefore patients must exhibit sufficient incompetence to be recognisably in need of therapy, but must also show they are trying to overcome this incompetence through personal effort. These two requirements are potentially conflicting. Too 'strong' a display of incompetence might suggest failure to try. Too 'strong' a display of trying might imply that the condition is in fact remediable through their efforts alone. Too strong a display of independent effort can also imply failure to co-operate and orient to the therapist's authority to direct activities. (We saw an example of this in S3Ph4PaMT1/2.09 in which the patient was sanctioned for beginning an arm exercise by himself).

Parsons' analyses have been criticised on several fronts. His original account of the model (Parsons, 1951) has been criticised for failing adequately to consider the situation of chronic illness (Freidson, 1975). He

answered these criticisms in a later explication of the model (Parsons, 1975). Arguably, a more fundamental criticism is that Parsons' conception of internalised and fixed rules and norms to which people conform in their behaviour is deterministic and incorrect (Wrong, 1961). Likewise, his conception that people are generally driven to conform to these rules by their desire for approval has been criticised as inadequately accounting for human motivations and conduct (Freidson, 1975). As discussed in the previous chapter, the underlying criticism is that Parsons' model leaves too little room for human agency, and fails to address the way people reason and make decisions. Parsons (1951) acknowledges that his model is based on ideal types and is thus somewhat abstract, and also asserts the importance of focusing on interactive processes in analysing the influences which shape people's conduct.

This brings us to Goffman's descriptions and explications of conduct in situations of physical incompetence and illness. In contrast to Parsons' emphasis on theory, Goffman's starting point consists of empirical and detailed observations of what people do. His findings are consistent with much that is proposed by Parsons' model, but also elaborate understandings of ill people's conduct because of this emphasis on actual behaviour. We begin by examining his description and explanation of 'able-bodied' people's responses to temporarily losing guiding control of their body, for instance when tripping up (Goffman, 1981b). Goffman here focused on the vocalisations ('oops' etc.) frequently made on these occasions – which he termed "spill cries". Goffman remarked that because they *advertise* the loss

of control to others, these cries seem puzzling. He argues that they nevertheless make sense in interactional terms. This is because they both depict what happened as *accidental* and show that the actor *knows it has happened*. In this way, they constitute an attempt by the person to insulate the loss of control from the rest of their behaviour. That is, in showing recognition, the person who has made the error conveys it as *not* due to "some general defect in competence" (p102). In showing it was non-intentional, they show they are sufficiently competent to know what *is* normal, despite the current abnormality. Their responses function to display that despite the lapse, they are competent at a wider or personal level; as Dingwall (1976) puts it, they convey that they are *essentially* competent.

Besides exploring conduct when experiencing momentary failures of the body, Goffman (1969) also described the conduct of people with medical impairment and prolonged physical incompetence. He remarked that the "interesting thing about medical symptoms is how utterly nice, how utterly plucky the patient can be in managing them" (p366). He notes that although they are unable to perform various mundane physical acts, "for each of these deviations from normal social appearance and functioning, the patient will be able to furnish a compensating mode of address" (p366). These 'compensating modes' entail such things as accounts, apologetic demeanour, and belittling of difficulties and discomforts. Compensating behaviours also involve embodied actions in the form of "physical cooperation that can be counted on" (p366). Thus in their demeanour and

actions people in this situation display consistent, co-operative, 'plucky' helpfulness.

Through this, they convey that they do not "*will* to be demanding and useless", and that they know "how to behave and would certainly behave that way were [they] physically able" (p366). That is, compensating behaviours serve to convey to others that incompetence is not wilful, that it is recognised, and that they are motivated to be competent if and when possible. Goffman noted that through these means, people whose physical incompetence is marked and prolonged continue to express support and acceptance of what is counted as normal within their social group. Thus their conduct contributes to social orderliness.

In summary, Goffman found, as Parsons proposed, that patients' actions are shaped to convey the legitimacy of their claim to disability, and to indicate their commitment to efforts to alleviate it in co-operation with institutionalised healthcare agents. Goffman additionally elucidated how people's conduct reflects an orientation to showing that despite their obvious physical disabilities they are nevertheless competent at some level. Displaying 'essential' competence entails various actions. These include showing that one at least recognises the incompetence and thus *knows* what is normal, and displaying competence in other activities or at other levels. These other levels may concern such things as cognitive and interactional abilities.

Goffman's description of helpful, co-operative conduct resembles the stroke patients' keen and aligned participation with physical treatment activities described in this chapter. Additionally, his explication of the way that conduct is directed at offsetting any interpretation of a more general 'defect in competence' helps explain elements of patients' and therapists' conduct that we will observe in subsequent chapters. Anticipating these findings, we will see that in dealing with failures of performance, both patients and therapists work to minimise the impact of the failure. They engage in actions which work to avoid or minimise the exposure and impact of incompetence, and also tend to emphasise patients' other capabilities and their 'essential' competence.

We have noted that Goffman's descriptions of patients' conduct and orientations are to a considerable degree consistent with Parsons' model. However, Goffman's conception of the explanation of those actions, what underlies them, differs considerably. Where Parsons saw actions of ill people and healthcare agents as determined by internalised norms and rules, Goffman, along with others such as Garfinkel and the ethnomethodologists who followed him, see conduct and orientation to 'norms' and 'roles' as locally and interactionally accomplished (see Heritage, 1984). Thus, ill people's 'roles' are constituted and enacted within local minute-to-minute interaction rather than derived from a body of external, *a priori* and regulative rules. As argued in the previous chapter, this understanding of the local constitution of roles and of the way people 'use' rules as interpretive rather than regulatory devices points to the necessity of observing people's

conduct, and through these observations explicating the orientations which shape that conduct. This approach is followed in the current study. We have already seen, and will see in subsequent extracts that patients and therapists do not blindly and uniformly follow one set of rules, and thus, conduct varies. However, variations are accountable and interpretable through a framework of 'rules' and procedures. For instance, we saw the therapist and patient in Extract S4Ph10PaRT3/10.24 treating the therapist's (rather unusual) failure to establish mutual understanding of the activity in hand as accountable.

4.4.1 Summary

Extracts in this chapter showed that patients generally follow therapists' instructions and convey a demeanour of alignment and co-operation. They respond promptly to instructions, use body movements, facial expression and vocalisation to convey effortful participation, and show keenness to 'get it right' – checking this with the therapist through gaze and questions. They tend not to question therapists' instructions, and mostly avoid instigating or determining activities by themselves²⁵. This keen, co-operative participation serves several functions. Through it patients show they are sufficiently competent to recognise that their conduct needs remediating, and display motivation to return to normal physical abilities. Showing such motivation

²⁵ When these arguments are referred to in forthcoming chapters, the term 'good patienthood' will form a shorthand way to refer to the configuration of patients' behaviours and orientations described here. This term is derived from its use by Murphy et al.'s (1998) when discussing how patients convey themselves in their accounts.

also counters the possible impression that current incompetence is intended or desired. In treating therapists as the leaders and orchestrators of therapeutic activities, patients exhibit orientation to therapists' authority to judge what counts as normal, competent physical conduct and to determine how this is to be achieved.

The above discussion has mostly focused on patients' conduct. This reflects emphases within Goffman's work, and to a lesser extent that of Parsons. However, the sociological perspectives examined above actually elucidate the conduct of *both* parties. The data show that portraying the patient as genuinely disabled but nevertheless making efforts to alleviate disability is a collaborative achievement, as is patients' motivation. In practical terms, this collaboration entails even simple details of conduct. For example, a therapist interactionally constructs collaboration through using the word 'we' rather than 'you' when talking about activities. A further example of collaboration is the way that both therapists and patients work to make effort recognisable by 'sharing' facial expressions of raised eyebrows and audible exhalations towards completion of a difficult activity. Likewise, both therapists and patients work towards the insulation of patients' conduct from 'wider incompetence'. For instance, when patients make errors in their physical performance, both patients and therapists produce accounts for these that are formulated in such a way as to counter implications that they reflect more general defects in competence (for concrete examples, see next chapter).

The constant and collaborative nature of these activities illustrates how the participants' conduct and roles are continuously constructed through practical, interactional work. This work would not be necessary if patients' and therapists' conduct was the automatic product of internalised norms and rules. Physiotherapy is not a situation in which fixed rules and roles govern what happens and thus automatically 'make' patients effortful, and therapists encouraging. Rather, by collaborative talk, body movements and actions they both *show* and *make* physiotherapy a situation in which the patient is effortful and the therapist encourages and directs.

In conclusion, Parsons' and Goffmans' sociological analyses help elucidate the conduct described in this chapter. We have given notice that they will also illuminate conduct encountered in forthcoming chapters. With respect to the current chapter, these analyses show the interactional significance of patients' effort displays and of the verbal and physical actions by which therapists work to motivate and encourage patients. We have also observed the constant and collaborative nature of the interactional accomplishment of 'working hard in physiotherapy', of 'being motivated', and of the therapist's authority. We argued that this indicates that rather than conforming to fixed, *a priori* roles and norms, patients and therapists constitute and enact their roles through local collaborative activity.

4.5 *The collaborative nature of orientation to authority*

As we noted in the literature review chapter, the significance of displaying effort, competence, and allegiance to returning to 'normality' have not gone

unnoticed by researchers of rehabilitation and physiotherapy. Some have suggested that professional authority and an ideology of functional independence are imposed upon patients in such a way as to limit patients' self-determination (Gold, 1983; Kaufman and Becker, 1986; Jongbloed, 1994). Parsons' and Goffman's view, and the evidence of this and other conversation analytic studies, suggest a more complex picture; in particular that these allegiances to independence and perseverance and to the therapist's authority are *not imposed* by therapists, but *collaboratively produced* by both parties.

This interactional achievement of authority has been clearly and 'technically' explicated (Maynard, 1991b) by a systematic and substantial body of CA studies of conduct in healthcare settings. Several of these have examined ways that medical authority and control is manifest in interactional conduct; grounding their analyses in detailed examination of recurring patterns of conduct in actual interactions (e.g. Heath, 1986a, 1992a, 1997; Frankel, 1996; Peräkylä, 1998; Pilnick, 1998). In contrast to analyses that stress the one-sidedness of professional control, such as the rehabilitation studies referred to in Chapter 2, this research has emphasised the complex array of demands upon *both* doctors *and* patients that characterise consultations. These studies acknowledge the existence of asymmetries of knowledge and activity between doctors and patients, but do not regard this as manifested solely in the exercise of professional control over patients. They show empirically that patients design their utterances and conduct so as to contribute to maintaining this control and authority: to "systematically

preserve the differential" between their understandings and those of the doctor (Heath, 1992a, p258). They also show that doctors do not treat their authority as automatically given.

Before examining some findings of the CA studies, we will explore the central arguments of the more 'traditional' and critical view of professional authority.

Sharrock (1979) has summarised this view:

"The professional is seen as being concerned to assert and sustain his dominance over the patient ... organising the encounter to prevent (virtually) the patient speaking any more than an absolute minimum, manipulating information and withholding it unnecessarily in order to back up his advantageous position in the interaction" (p133).

Alongside the assumption that clinicians unilaterally impose control and dominance, there is also an assumption that if patients were only allowed to speak, then they would have more to say. Also, according to this perspective, the professional's communication practices, especially their questioning formats (Maynard, 1991b) are regarded as the means by which their authority is imposed. This view, more or less strongly held, underlies several studies and reviews of physiotherapy and stroke rehabilitation (e.g. Kaufman, 1988; Stachura, 1994; Dahlgren, 1998; Williams and Harrison, 1999). For instance, Thornquist (1994a), analysing physiotherapists' interactions with patients, concludes that: "therapists controlled the content and form of the dialogues so that the patient's own version was allowed little place" (p707). This view of how therapist patient interactions function is also implied more or less directly in the tone of recommendations for communication practice

made in some studies (e.g. Partridge, 1994; Thornquist, 1994a), and formulated by professional bodies (ACPIN, 1995; CSP, 2000). All these urge therapists to give patients more opportunities to speak and to avoid dominating them. Sharrock (1979) deconstructs this 'traditional' view of medical authority from a theoretical standpoint. He acknowledges that some sort of interactional control is in operation in these encounters, particularly in constraining patients' actions. However, he asserts that structures of talk are not a particularly strong constraint, and "could not contain or control anyone who genuinely wanted to raise the topic and was willing to try to get answers to their questions" (p142). Thus, some other form of constraint must operate.

In summary, one influential analysis of medical interactions holds that professionals unilaterally impose dominance and authority over patients, and further, that patients have more to say, but do not say it because they are not given opportunities to do so. However, it has been argued that the communication patterns by which this dominance is said to be imposed are relatively weak constraints and would not be sufficient to silence patients were they determined to speak.

Besides theoretical arguments, there are also empirical findings from close analyses of actual interactions that contradict the proposals of the 'traditional' view of authority. These analyses concur with some aspects of the traditional view, in that they too have found that overwhelmingly, patients' interactional contributions to medical interactions are constrained in certain directions, and that interactions are fundamentally asymmetrical. However, they do not

concur with the view that these constraints originate solely from, and are unilaterally imposed by clinicians. Instead, they find that parties mutually collaborate in constructing professionals' authority and hence the asymmetrical nature of the interaction (Maynard, 1991b; Heath, 1992a; Pilnick, 1998). Turning to some specific examples: it has been shown that even when provided with opportunities to do so, patients rarely ask questions, interject, or express direct disagreement following provision of diagnoses (Heath, 1992a; Peräkylä, 1998). Nevertheless, patients *do* at times make demands upon the doctor: seeking further information (ten Have, 1991), encouraging the doctor's attention (Heath, 1997), and encouraging certain lines of enquiry and diagnostic conclusions (e.g. Maynard, 1991a). However, when patients perform such activities, they regularly do so through subtle and covert devices, which mitigate the directness of these actions, and mitigate any implication of challenge to the doctor's authority (e.g. ten Have, 1991; Frankel, 1996). That is, patients pervasively *constrain their own interactional activities*, and apparently do so even when explicit opportunities are provided for alternative conduct; nevertheless, they do make demands upon clinicians, such as for their attention, or for a diagnosis.

The conversation analytic studies mentioned above have contradicted assertions that patients are passive within interactions; that they would say more if they could; and that constraints on their conduct are unilaterally imposed by clinicians. The data examined in this chapter follow a similar pattern. For instance, analysis showed that even when therapists' instructions are couched in tentative rather than authoritative terms, such that

questioning them would be relatively easy in interactional terms, most patients comply with instructions without questioning or resistance.

Additionally, we saw that patients do on occasion question therapists, albeit tentatively and indirectly (Extract S4Ph10PaRT3/10.24). Patients are not the passive, downtrodden participants portrayed by some analyses, rather, they actively employ varied and subtle verbal and physical resources to express their views and get their interactional needs met, whilst also upholding medical authority (e.g. ten Have, 1991; Heath, 1997).

Arguments that patients are 'forced' to be passive extend to physical aspects of interactions. For instance, therapists have been criticised for focussing on patients' bodies, or isolated parts thereof, 'objectifying' patients whilst neglecting psychological and social aspects of their experiences and complaints (Chapter 2, Section 2.1.1.1). However, when we analysed conduct during treatments performed upon patients (e.g. S1Ph2PaHT3/11.44), we observed that patients actively control their body, transforming *themselves* into phenomena under inspection (Heath, 1986a, 1992a). This contrasts with perspectives that see the transformation of patients into bodies for inspection as purely the result of the actions and perspective of the professional.

Having considered patients' conduct, as proposed by the 'traditional' view and as observed by studies of actual conduct, we now turn to clinicians' conduct and the argument that they unilaterally impose their authority.

Another CA study (Peräkylä, 1998), has shown that this view of authority is

not borne out by clinicians' actual conduct. Peräkylä showed that doctors regularly treat themselves and their medical actions, specifically their diagnostic reasoning and diagnosis, as accountable to patients. He argues that doctors treat patients as understanding recipients, and treat their own professional authority as requiring warrant and substantiation through ensuring that reasons underlying their diagnoses are available to patients. Other studies have shown that doctors vary and change their communication in response to the situation and expressed views of patients (e.g. Maynard, 1991b; Heath, 1997). Clinicians' conduct thus seems under greater influence by patients than is suggested by the traditional view, and they do not treat their own authority as given and automatic as has been suggested. We shall see subsequently in this thesis that the physiotherapists' conduct suggests the same orientation to warranting rather than imposing their authority. For instance in the next chapter we will see that when assessing patients' errors of performance, therapists do not authoritatively and directly pronounce their evaluations, but in various ways account for production of critical assessments, particularly by proposing associated remedies. Even when producing positive assessments, therapists regularly provide elaboration that details the evidence underlying their assessments.

A further element of the re-examination of the nature of asymmetry in clinical interactions entails the proposal that the interactional patterns seen (asymmetrical contributions, and sparseness of information provision by clinicians) arise because they are 'inherently functional' (see ten Have, 1991, footnote1). Maynard (1991b) proposes, and examines data which

demonstrate that: “asymmetry and other features of clinical discourse ... derive partly from participants’ indigenous resolution of interactive problems” (p449). Thus, it is argued that the patterns arise at least in part because they provide the most efficient way of dealing with the practical clinical objectives at hand. We would suggest that there is evidence for this in the organisation of conduct observed in the physiotherapy data. For instance, the patterning of instruction-response sequences allows for activities to be rapidly and efficiently instituted and sustained during sessions in a way that would not be possible were patients to pass comment more, or question instructions, or propose and initiate activities themselves. Further extracts in subsequent chapters will also illustrate that ‘practical clinical objectives’ in terms of the performance of treatment activities can be interrupted or disrupted if there is substantial dialogue between therapists and patients at these times (for instance lengthy explanation and information giving about activities and abilities), that is, that greater dialogue can make for less ‘efficient’ achievement of some clinical activities.

Findings of detailed studies of actual interactions show that the medical control and asymmetry visible therein are enacted and constituted by the collaborative actions of both parties (ten Have, 1991; Pilnick, 1998). Also that the degree of asymmetry and of patients’ interactional contributions varies in extent both within and between encounters (ten Have, 1991; Pilnick, 1998). Rather than being the malign force assumed by the traditional view, authority and asymmetry are a necessary element of medical interactions. This is because they fundamentally underpin the logic or rationale of seeking

and complying with healthcare professionals' assistance (Heath, 1992a). Overtly resisting physiotherapists' instructions and assessments would inevitably undermine the point of and grounds for participating in physiotherapy. Both parties collaborate in establishing authority, with the asymmetry that entails, because both have an interest in upholding authority. Upholding authority is not only important for maintaining the rationale of participation; it is also associated with the management of physical incompetence as we will discuss further later in this thesis (especially in the final chapter). Additionally, the associated patterns of conduct appear to represent efficient means for both therapists and patients to achieve practical clinical tasks.

Ten Have (1991) points out that underlying the critical view of medical interactions is an assumption of the "morality of equality" (p139) - that more symmetrical forms of interaction are somehow preferable. He points out that asymmetry, and interactional dominance by the clinician is in fact a quite 'natural', and unavoidable part of these interactions because both the topic (the patient's rather than the clinician's health) and the tasks of the respective parties are asymmetric. As we have seen throughout this chapter, physiotherapists' and patients' topics and tasks during physiotherapy differ. It has perhaps seemed rather simplistic to labour this point, but it is important to do so because it seems that the assumption of the 'morality of equality' underlies many of the recommendations for good communication practice. This assumption is blind to the unavoidable and abiding asymmetries of the situation of clinicians and patients. The recommendations are thus founded

on a false premise, and this limits the compatibility between their guidance and the circumstances of actual interactions. Inevitably then, their applicability to practice is severely limited. If recommendations were to take into account these elements of inequality, but also that the associated asymmetry and therapist control are variable in extent, then their stipulations would be able to address more specifically how patients *could* be encouraged to participate and be involved in clinical interactions and decision-making (see Chapter 7, Section 7.2.4.2).

4.6 *Relationship between observed practices and the recommendations for practice*

We will now reflect on how actual conduct compares to recommendations for good practice. The recommendation that mutual understanding is established between therapist and patient is almost inevitably fulfilled with respect to understanding the nature of treatment activities and of expected participation in them, because this understanding is necessary for performance of therapy itself. Likewise, patients' involvement, which is strongly emphasised by the recommendations, is essential to performance of the activities. We have shown how, even during treatments in which patients seem relatively passive, they are in fact interactionally active and involved.

However, other aspects of practice seem inconsistent with the recommendations about ensuring patients' understanding and involvement. Obstacles to implementing recommendations are presented by the mutual orientation to the therapist's authority to determine and control the activities

that are performed, and to the patient's role as keen, co-operative, aligned responder to instructions. Also (as we will see more clearly in the following chapter), by the orientation to the therapist's role in legitimating the nature of the apparent incompetence, and the patient's role in displaying both the genuineness of the incompetence, and their commitment to remediating it. The mutual orientation to the therapist's authority restricts the degree of patient involvement and incorporation of patient preferences into treatment content. It makes for a situation of dependence on the therapist, which is contrary to the recommendations. The patient is clearly not treated as an equal to the therapist with respect to determining what, when and how activities are performed. We observed a restriction of patients' talk about activities, and that they rarely initiate actions themselves, also that the degree of this restriction varies depending on the type of treatment activity. As shown by the extracts, patients' talk appears more constrained when activities involve physical guidance of the patient by the therapist than when movements are performed with the therapist's 'hands off'. Patients' contributions are even more constrained when the treatment involves actions that therapists perform upon the patient. It seems patients avoid taking any action which might be read as commenting on the performance and activities of the therapist.

In summary, data showed that therapists are treated by both parties as the leaders in this area of interaction, and that patients recurrently orient to being keen and co-operative followers of instructions, rather than instigators of activities. Thus their roles and their interactional actions and opportunities

are inevitably different, and this must conflict with the recommendation that patients should be treated as equals, and must also affect the degree of their involvement. Indeed, careful consideration of the situation of physiotherapy raises questions as to whether treating patients as equals is a feasible or appropriate recommendation (see Chapter 7).

Some of the specific communication practices described in this chapter run counter to recommendations. In particular, therapists' ambiguous instructions may limit establishment of mutual understanding. In the next chapter (Section 5.4.5), we will examine further sequences involving vague, ambiguous instructions, and discuss them in more detail. Also, we have shown that patients' involvement is more limited during treatment activities where the therapist is touching the patient. One might suggest that this form of activity should therefore be avoided. However, tactile guidance of patients' movements is often a vital part of treatment. If therapists wish to endeavour to maximise patients' interactional involvement, then they need to be aware of the way guided treatment activities and those performed upon the patient constrain patient's interactional contributions to the activity.

Other practices encountered in this chapter seem to contribute more positively to enactment of the recommendations. Patients' indications of their participation, even though usually non-verbal, are a form of involvement and of expression of their perceptions. By attending to and acknowledging patients' indications of their participation, therapists treat them as participating individuals; encourage their involvement; and can constitute

participation as mutual, despite the differences between the parties' orientations, actions and resources. Further, in acknowledging and treating indications of effort, concentration and so on as appropriate, therapists contribute to patients' understanding of what is expected in physiotherapy treatment.

By soliciting and responding to patients' reports and assessments about their participation in activities, therapists facilitate the expression of patients' views. Doing so also contributes to enacting the recommendations to involve patients, treat them as experts in their own right, check understandings, and make the relationship one of mutual participation.

This chapter has focused on the practices and orientations that are manifest in the introduction of treatment activities and in patients' initial responses to them. In the next chapter, we consider how therapists and patients develop and display understandings about success and failure of performance of ongoing activities. As we will see, patients' and therapists' conduct in this area is again influenced by pervasive orientations both to therapists' authority to determine the nature of treatment activities and to the demonstration of 'good patienthood' through keen, unquestioning and co-operative demeanour and actions. However, in management of success or failure of performance, additional orientations are apparent. These concern generic social orientations to giving and receiving complementary and critical assessments.

CHAPTER FIVE

ACHIEVING UNDERSTANDINGS ABOUT THE SUCCESS OR FAILURE OF PATIENTS' PERFORMANCE OF PHYSIOTHERAPY TREATMENT ACTIVITIES

5.1 *Introduction*

Successful performance of physiotherapy treatment activities depends upon mutual understanding about their nature and about the participation required, as explored in the previous chapter. Once performance of an activity has commenced, shared understandings about its success or failure are central to maintaining participation, correcting errors, and making progression from one activity to the next intelligible. Interactions about success and failure are the topic of this chapter. These interactions occur frequently throughout the sessions and generally involve production and reception of assessments or evaluations, as well as other practices. In assessments, speakers indicate a sense of their experience (Pomerantz, 1984a) rather than merely reporting²⁶ observations and experiences. The subject of an assessment is the referent i.e. that which is observed or experienced (Pomerantz, 1984a). Hence, when one assesses, one expresses views, opinions, judgements, appraisal or interpretation of a referent (Heritage and Stivers, 1999). In this thesis, the terms assessment and evaluation will be used interchangeably. However, evaluation is used particularly for talk that indicates a sense of positive or

²⁶. In reporting, the “speaker lists the details of his or her situation without stating its implications or officially taking a position” (Maynard, 1991a, p155).

negative appraisal, i.e. success or failure. In the physiotherapy data, both current performance and overall progress form the referents of evaluations. For analytic clarity and feasibility, our main focus will be evaluations of current performance.

Much of this chapter concentrates on the interactional management of *failures or problems* of performance of activities. This is because management of the mistakes patients make in their movements is a substantial element of physiotherapy: if treatment is to progress, indicating and repairing problems and achieving patients' understanding about these is essential. Through data extracts, we will see that patients and therapists treat problem indication and repair as salient but also delicate matters, which usually involve greater interactional complexity than success and its assessment.

Orientations to therapists' authority and to keen co-operative participation by patients that were shown to shape conduct described in the previous chapter can also be seen to influence the way that success and failure are dealt with in physiotherapy. However, other orientations contribute to shaping conduct in this area, in particular a recurrent '*preference organisation*' in how assessments and other-corrections are given and received in social interactions. Previous research describing this preference organisation will be summarised at the beginning of the chapter.

5.1.1 Structure of the chapter

Existing conversation analytic understandings of the production and reception of assessments, and of corrections/repairs of co-participants' activities will be reviewed. This will provide a foundation for the analysis in this chapter, and will encompass a description of preference organisation. Findings concerning both 'ordinary' or 'casual' conversations and interactions in institutional settings will be described. After this, a series of data extracts will be presented. Following a short section on production and reception of positive assessments, a longer section examines negative evaluations of patients' performance.

As we analyse the extracts, we will examine the different ways in which therapists and patients instigate and respond to evaluations and the different orientations their actions reveal. Particular attention will be paid to two areas of patients' conduct: their production of self-evaluations and their response to failures of performance. For therapists' conduct, analysis will focus on the range of practices by which they manage patients' failures whilst also working to maintain motivation and participation in the face of failure.

Towards the end of the chapter, we will examine extracts in which parties solicit, or attempt to solicit, evaluations from each other. These extracts are particularly illustrative of how patients and therapists orient to each other's rights and authority to make judgements about performance. In particular, they shed light upon patients' frequent reluctance to provide evaluations of their own performance.

Assessments of performance, both positive and negative, occur during a large proportion of the treatment activities recorded in these data. This has facilitated identification and selection of examples of both recurrent conduct - patterns which commonly occur in these data, and atypical conduct - patterns which rarely occur in these data. Both will be illustrated and described in the text.

As in each area of interaction explored in this study, analysis not only *describes* observed patterns of conduct, but also draws upon sociological perspectives in order to *elucidate* the 'good reasons' for therapists and patients to behave in the way they do. These perspectives will inform discussion of the relationship between actual conduct and that proposed by professional recommendations. At the end of the chapter, specific practices will be re-examined with respect to their capacity to meet the demands of both the recommendations and of broader social constraints and orientations.

5.2 Literature review: preference organisation, assessments and repairs in ordinary conversations and institutional contexts

Here we review several interrelated bodies of CA findings. First, we briefly explore the concept of preference organisation. We then turn to production and reception of assessments/evaluations in ordinary conversations. This will allow us to further explain how preference organisation operates. Since, as already hinted, assessments are closely associated with corrections of patients' performances in the physiotherapy data, we will also review CA findings about corrections and repairs in ordinary conversation. The final part

of the review concerns institutional settings, particularly classroom and medical interactions. We will describe findings of studies that have analysed production and reception of assessments and of corrections/repairs in these environments, and consider their relevance to the physiotherapy setting.

5.2.1 Preference organisation

Preference organisation refers to a generic feature of human interactions, it concerns systematic patterns in the design of certain communicative actions. It is difficult to briefly summarise the concept without oversimplifying and omitting significant elements, however, ten Have (1999) provides a useful foundation:

"The general idea is: that when alternative actions are open possibilities, one may be 'preferred', that is, expected and chosen if possible²⁷ and that the difference between 'preferred' and 'dispreferred' alternatives is demonstrated in the *turn shape*²⁸ chosen for doing one or the other. In other words, turns can be designed to *show* they are doing the preferred, or the dispreferred, alternative action" (p120).

²⁷. Ten Have's brief description of preference organisation inevitably sacrifices some specification; an example of this is the phrase 'chosen if possible', which lacks some accuracy. As Heritage (1984) explains, even when it would be *possible* to do that which is preferred, people can and do choose to do otherwise. However, when they perform a dispreferred action, people orient to its potential accountability, and the interpretations others may make of it.

²⁸. Preference organisation may be seen in the shape of the sequence as well as the turn.

Besides this 'turn shape aspect' of preference, a further facet of preference organisation "has to do with structural regularities as to which kinds of alternatives are generally preferred or dispreferred" (p120).

Preference organisation informs and is manifest in the production of a variety of actions. These include those that are broadly second parts within sequences such as agreements and disagreements, acceptances and rejections; and those that tend to be first parts of sequences, such as blamings and corrections.

Saliently for this chapter, assessment production and reception tend to be performed and interpreted according to a preference organisation (Pomerantz, 1984a). That is, certain sorts of assessments and responses are preferred, and others dispreferred. In particular, assessments that are critical of a co-participant are generally dispreferred, as are disagreements with assessments produced by co-participants, although this is not an invariable orientation. For instance, when a co-participant's assessment is self-critical, disagreement is the preferred response (Pomerantz, 1984a). We will shortly explore Pomerantz's seminal findings on assessment sequences and on the form and implications of their preference organisation. Before doing so, it is important to point out that the terms 'preference' and 'dispreference' do not refer to speakers' internal desires or attitudes. On the contrary, they concern highly generalised social and institutionalised patterns of speaking (Heritage, 1984). That is, preference organisation refers to a

social rather than psychological phenomenon and is an important element of the interactional mechanisms by which we understand each other, design our own actions and interpret those of others.

5.2.2 Assessments in ordinary conversation

We now turn Pomerantz's (1984a) findings about assessments.

Assessments occur frequently and routinely in ordinary conversations.

Producing and responding to them is a fundamental way in which we participate in activities and display co-participation with one another. Besides their inherent link with *participation*, assessments are bound up with *knowledge* and claims of access to knowledge. When someone produces an assessment, they imply and indicate that they have access to knowledge of that which is assessed. Conversely, unwillingness to provide an assessment implies lack of knowledge and may be explicitly accounted for in these terms. Likewise, when responding, a recipient can indicate either access or lack of access to knowledge of the referent.

Assessments also give indications about participants' attention. Production of an assessment draws and guides the recipient's attention, and their response indicates their attention (or not) to the referent. Thus, when someone produces or responds to an assessment they indicate aspects of their participation, knowledge and attention. All these aspects are central to physiotherapy, and we can thus begin to see that assessments and responses form central interactional resources within it.

Pomerantz notes that recipients sometimes respond to assessments with acknowledgements (e.g. 'uh huh') and news receipts (e.g. 'oh really'). Responding this way does not involve claims to independent knowledge and evaluation of the referent, and expresses neither agreement nor disagreement. In ordinary conversation, Pomerantz found that recipients more frequently produce a response that is agreeing or disagreeing and do so through production of a second assessment. We will turn to this form of response now.

We have noted the association between the preference status of an action and the turn shape in which it is produced, and this is evident in responses to assessments. 'First assessments' are regularly structured such that one next action is invited over its alternative. For instance, agreement may be invited over disagreement. Pomerantz describes a next action that is oriented to as invited as a *preferred next action*, and the alternative a *dispreferred next action*. When an assessment invites agreement, responses are differently formulated depending on whether they agree (i.e. are preferred) or disagree (i.e. are dispreferred). Generally, agreements are accomplished with stated and explicit agreement components, and agreeing turns are composed of exclusively agreeing components. They are performed with little or no gap between prior turn and agreeing response. In contrast, disagreements are often prefaced or delayed in some way, and there is a greater variety in their form than in that of agreements. Sometimes disagreements are not directly stated at all, and when stated they are often 'weak forms', for instance combined as partial agreements / partial disagreements. Thus,

disagreement turns and sequences often contain agreement components as well as disagreement ones. Disagreement components are frequently delayed within a turn or sequence through such things as silences, prefaces such as 'well' and 'uh', partial agreements, qualifications, requests for clarification and other repair initiators. This recurrent delay or avoidance of stated disagreement constitutes an interpretive resource, so that co-participants infer that lack of response to an invitation or first assessment indicates an 'as yet unstated' negative or disagreeing response (Pomerantz, 1984a, p95).

So far, we have described how preference organisation can be visible in and through the way an assessment is produced and the way it is responded to. Also, that this organisation is such that recurrently, agreement between participants is preferred (though not always – see below). Research has found that preference organisation shapes and is visible in the production of other actions, such as responses to requests and invitations, for which acceptance is recurrently preferred (Davidson, 1984).

We have been concentrating on situations in which agreement is preferred, as is recurrently the case in assessment sequences in ordinary conversations. However, as noted, this preference is not invariable. One circumstance in which *disagreement is preferred* is when a speaker produces a self-critical assessment. Pomerantz (1984a) showed that when this occurs, the recipient tends to disagree with the self-deprecation. Indeed, criticising a

co-participant and agreeing with self-critical evaluations are both generally avoided or performed in delayed and indirect ways.

From her comprehensive descriptions, Pomerantz draws the following conclusion:

“across different situations, conversants orient to agreeing with one another as comfortable, supportive, reinforcing, perhaps as being sociable and as showing that they are like-minded..... Likewise, across a variety of situations conversants orient to their disagreeing with one another as uncomfortable, unpleasant, difficult, risking threat, insult or offense” (p77).

Thus, Pomerantz’s findings (as well as those of other conversation analysts, see Heritage, 1984) show that people tend to agree or at least not overtly disagree with one another, and avoid controversy and open conflict.

Pomerantz elucidated a central part of the mechanism by which this is interactionally accomplished. Through dispreferred turn shapes, an interactant can imply but not state opposition, refusal etc., and can allow a co-participant to take actions to forestall disagreement and enable agreement. That is, since it is foreshadowed interactionally, overt disagreement can be averted. In this way, dispreferred actions, such as disagreement and criticism are minimised, delayed or avoided through the interactional construction of people’s talk.

The association between the preference status of an action and its turn or sequence shape thus has important interactional functions. These systematic characteristics allow each of us (whether interactional participant or analyst of the interaction) to 'know' what is being done. They allow us to recognise, even in the midst of its production, whether an action is preferred or dispreferred. Not only does this allow us to recognise and interpret other people's actions, such as their agreement or disagreement, it also allows us to design our own conduct, and this can include the modification of our own position so as to facilitate certain occurrences and avoid others.

The different orientations to agreement and disagreement with assessments that Pomerantz described prevail across interactional settings. However, production and reception of assessments in institutional settings and ordinary conversations differ in some respects. Ordinary conversations often concern and reflect the co-participation of peers in shared activities, whereas many institutional settings entail more asymmetrical forms of participation. For instance in many tasks, such as teaching of various forms (McHoul, 1985; Curley, 1998), orchestral rehearsals (Weeks, 1996), and physiotherapy, one person is 'directing' whilst the other is 'performing', displaying, or practising. In this situation, something particular is assessed: the client's, patient's or student's responses to directions. Thus, one participant's assessments of the other's performances predominate. This difference compared to ordinary conversation has certain implications. First, we might expect agreeing and disagreeing second assessments by recipients to be less likely because these situations involve asymmetries of knowledge and authority. Lack of

production of second assessments by students, clients and patients has indeed been found, as we will discuss below. Second, we can expect that negative assessment or criticism of one participant by the other will be more frequent. Thirdly, and linked to this, these assessments often form part of sequences which also involve corrections. This is because the assessment or criticism is produced as part of the institutional task of correcting some aspect of the client's, student's or patient's response / performance. Therefore we will now consider how repairs and corrections are performed in ordinary conversations in order to extend the basis for examination of related institutional conduct.

5.2.3 Corrections / repairs in ordinary conversation

Schegloff et al. (1977) described and analysed a systematic organisation by which troubles of speaking, hearing and understanding are managed in ordinary conversations. They advocated use of the term 'repair' rather than correction for these processes because they noted that indication of the occurrence of a repairable does not necessarily lead to accomplishment of a correction. They note that repairs are performed either by the current speaker: 'self-repair', or by a co-participant: 'other-repair'. Self- and other-repair are performed in different ways, and they also differ in their preference status. Self-correction is "vastly more common" (p362), and also more likely to occur because of the sequential organisation that people orient to in doing repairs. Thus, there is a preference organisation to the effect that self-repairs of problems of speaking are preferred to other-repairs.

Schegloff and colleagues point out that repairs can consist of two parts: initiation of the repair, which involves indicating the presence or location of a trouble source; and performance of the repair, where the trouble is specifically dealt with. Self- and other-repairs differ in terms of the placement of the repair, the technique by which it is done, and the sequence or trajectory that follows initiation of repair. Self-repair often occurs within the same turn as the trouble source, and is achieved or resolved within that turn. On the other hand, co-participants generally withhold repair initiations during the turn that contains the trouble-source, i.e. they do not interrupt the turn in progress, indeed they may leave a slight gap before commencing any trouble indication – as if to provide an extra opportunity for self-repair. Also, even where ‘other’ takes some action, this is most often an indication of a trouble source, rather than production of a full-blown correction. Finally, if ‘other’ does correct their co-participant, this is frequently done in modulated form: expressed with some uncertainty, or as non-serious, or as an ‘understanding check’ in which the correction is “not asserted, but is proffered for acceptance or rejection” (p379). Thus in the sequential organisation to which participants recurrently orient, repair within conversation “provides centrally for self-correction” and is “so organized as to favor self-initiated self-repair” (p377).

Schegloff et al. note an exception to this organisation during interactions with children. That is, children are regularly corrected by others without modulation. They argue that other-correction can thus be “a device for dealing with those who are still learning” (p381), and occurs more frequently in interactions with those unable, or not treated as able, to adequately self-

monitor and self-correct. Studies of adults with language impairments (e.g. Booth and Perkins, 1999; Heeschen and Schegloff, 1999) have borne out these findings: in conversations with them, some co-participants²⁹ frequently and directly indicate and correct their problems of speaking.

Jefferson (1987) has elucidated further aspects of repair organisation in ordinary conversations. She described a distinction between 'exposed' and 'embedded' repairs. In exposed repairs whatever "has been going on prior to the correcting is discontinued. Where prior utterances have been occupied with various ongoing matters, utterances are now occupied by the doing of correcting" (p88). Exposed corrections are characteristically accompanied by other activities, which deal with accounting for the conduct that led to the repair. These attendant activities include instructions, complaints or sanctions, admissions, forgiveness, reassurances, and apologies. Thus, exposed corrections can involve not just putting things right, but also "specifically addressing lapses in competence and/or conduct" (p88). Embedded corrections differ in that the correction does not become the interactional business, but happens "as a by-the-way occurrence in some ongoing course of talk" (p95). Embedded corrections do not provide sequential 'space' for attendant activities such as accountings. Thus they

²⁹. Specifically, relatives and friends have been found often to do so, whereas in some situations, especially (though not always) in institutional settings, e.g. interactions with speech and language therapists, co-participants tend to avoid direct exposure of the language impaired person's incompetence (Booth and Perkins, 1999; Perkins et al., 1999; Heeschen and Schegloff, 1999, Footnote 3).

can be a way by which issues of incompetence are kept off the interactional surface: they form a resource for 'discreet' correction.

Therefore, if a problem is to be directly addressed, if understandings about it and accounts for it are to be developed and checked through talk, and its correction is to include detailed instruction, this requires an exposed repair. When this form of repair is performed, the previous, ongoing activity is interrupted or disrupted because the topic changes to that of the trouble source and the repair.

It should be emphasised here that within this chapter we will be using the word 'repair' in the context of physiotherapists' practices when dealing with patients' failures/shortcomings of movement activities. These 'repairs' have similarities but also dissimilarities to those described and analysed by Schegloff et al. and Jefferson. One similarity to Schegloff et al.'s analysis is that, as they emphasise, repair is not necessarily analogous to correction in that reparative actions do not necessarily result in the error or mistake being replaced by the 'correct' version. In physiotherapy, attempts to manage patients' movement problems do not necessarily result in 'correct' movement activity. This is why we will not refer to therapists' practices simply as corrections of patients' actions. Our use of 'repair' in this physiotherapy context nevertheless differs from Schegloff et al.'s and Jefferson's use in that those analysts were referring to repairs of problems of speaking, hearing and understanding, whereas we refer to repairs of movement shortcomings. Also, more subtly perhaps, Schegloff et al, note that the repair actions they

refer to are “not contingent upon error” (p363), such that they are sometimes found when there is “no hearable error, mistake or fault” on the part of the speaker (p363). In contrast, in each episode with which we will be concerned, there does appear to be some ‘error’ on the part of the patient. Additionally, Schegloff et al. analysed repair practices in terms of two components: ‘initiations’ and ‘corrections’, and noted that dealing with problems of speaking, hearing and understanding could be achieved through initiations alone, without actual corrections. We will analyse therapists’ practices in terms of separate elements: ‘problem indications’, and ‘repairs’ of problems of movement, indications being some form of relatively direct reference to the error or shortcoming. Whilst Schegloff et al. noted that in their data, initiations regularly resulted in repair actions – without any direct correction, we will see that in physiotherapy repairs of problems are regularly instigated without any accompanying direct problem indication.

5.2.4 Assessments and repairs in institutional settings

We now move to studies of institutional settings. A variety of situations in which professionals have occasion to produce negative evaluations and repairs with respect to clients have been studied; one is teacher-student interaction, which has several parallels to physiotherapy. Research has examined how teachers deal with pupils’ answers to questions, including the way they assess and correct ‘wrong’ responses (McHoul, 1985; Hindmarsh, 1992). McHoul notes recurrent three-part sequences in teacher-student interactions which differ from the recurrent two-part adjacency pair

sequences of ordinary conversations (Sacks, 1992). In these three part sequences, evaluations form the third part:

- Question
- Answer
- Comment/evaluation, often linked to a further question

Research has found that when pupils' answers are 'right', teachers directly and immediately confirm and agree with these, whereas teachers rarely directly identify errors, they tend "to *withhold* other-corrections which, after all, they could so easily provide given that teachers routinely know the answers to questions they ask" (p61). Rather than directly addressing the deficiencies of students' answers, teachers re-specify questions and/or give prompts and clues. Re-specifying questions and 'clueing' are recurrent repair strategies in this setting (McHoul, 1985). Thus, as in ordinary conversations, directly criticising a co-participant is dispreferred, and other-correction is performed with delicacy. Similar findings in other settings have been reported. For instance, counsellors deal delicately with 'unwanted' responses by counselling participants (Jones and Beach, 1995), and speech and language therapists frequently avoid direct reference to and direct correction of patients' non-competent talk (Booth and Perkins, 1999).

There is also a small body of research concerning situations in which the errors indicated and repaired concern bodily actions, these include orchestral rehearsals (Weeks, 1996), and teaching the intricate movements of a Japanese tea ceremony (Curley, 1998). In these situations, bodily action

forms both the topic of, and a resource for repair. Parallels between the specific practices described in these studies and those in the physiotherapy data will be mentioned at relevant points in our analysis.

In all these studies it has been found that pupils and learners generally do not challenge teachers'/directors' assessments and disconfirmations.

From the findings reviewed thus far, we might anticipate that in the physiotherapy data, there will be greater occurrence of negative evaluation, criticism and correction of one co-participant (the patient) relative to ordinary conversation. Also, that even though therapists know the 'correct' movement just as teachers know the 'correct' answers, they will manage patients' errors of performance delicately rather than bluntly pointing them out. We might also predict that like classroom students, patients will align with rather than challenge therapists' evaluative and corrective actions.

We now turn to related CA studies of doctor patient interactions. Doctors' assessments in the form of medical diagnoses have received attention in several studies (Ten Have, 1991; Heath, 1992a; Peräkylä, 1998). It should be noted that diagnoses constitute a particular form of assessment, tending to occur in specific circumstances, and being based upon specialised medical knowledge. Thus in several features they differ from the general assessments discussed in literature about assessments in ordinary conversation (see above). Also, we should note that although doctors' consultations are similar to physiotherapy interactions in that they are

interactions between patients and clinicians, there are significant differences in terms of the activities that are performed. These include aspects of assessment production and reception.

In medical consultations, diagnoses are the central form of doctors' assessment production about the patient and specifically, about their deficits (Heath, 1992a). In parallel to teachers' assessments of students' answers, it has been found that patients rarely challenge doctors' diagnoses and prescriptions (Heath, 1992a; Peräkylä, 1998). Patients often respond to diagnoses with acknowledgements such as 'er' or 'yeh', and by withholding responses altogether (Heath, 1992a). On the rare occasions where a patient attempts to counter a doctor's diagnosis, they do so through indirect or tentative means (Ten Have, 1991; Heath, 1992a) and in such a way as to avoid competing with or challenging the doctor's knowledge and authority (Heath, 1992a).

In contrast to the pattern in settings so far considered, it has been found that doctors frequently produce their diagnoses and also their prescriptions for remedying problems in a direct form (Heath, 1992a; Peräkylä, 1998).

Several factors may explain the contrast between the frequent 'blunt' assessment and talk about patients' deficits by doctors and the infrequency of direct negative evaluations and repairs by such groups as counsellors, teachers, and therapists. These factors relate to the differences between medical consultations and other clinical interactions alluded to above.

Medical consultations are structurally different in that they tend to be far

shorter, time restrictions therefore limit the amount of talk and explication possible. Also, the referents of assessments and repairs differ considerably. Assessments in therapy and classroom settings concern personal competence and have the potential to be personally implicative and critical in a different way, and to a different degree, compared with medical diagnostic assessments. There are several reasons for this. A doctor's diagnosis does not constitute an assessment of a person's performance or response in the way that a teacher's or therapist's assessment does. Furthermore, in therapy and the classroom, teachers and therapists are eliciting responses – displays of knowledge or movement – that there are reasonable grounds to expect the student/patient will be able to produce, or at least try to produce. In contrast, medical diagnoses generally concern referents and knowledge of which the patient is not expected to have substantial competence, and indeed trying to produce one's own diagnostic assessment prior to the doctor is not greeted positively in these situations (Heath, 1992a). In summary, when teachers indicate 'wrong' answers or therapists indicate shortfalls in physical or cognitive capabilities, this can imply personal incompetence in a way that medical diagnoses do not.

Some medical diagnoses *are* treated with delicacy, and two particular circumstances have been reported in which doctors produce them in indirect, delayed and/or modulated form. These are where diagnosis is treated as potentially controversial, for instance because it is incongruent with a patient's stated or implied view (Maynard, 1991a; Peräkylä, 1998); and circumstances where the diagnosis is treated as 'bad news', often where

shock or emotional distress may be anticipated or expectable (Maynard, 1991a). These situations can also occur in combination, and when they do, are also subject to delicate management (Maynard, 1991c).

In situations of potential disagreement, doctors often produce evidential backing for their diagnoses: they produce some explanation of the reasons underlying it (Peräkylä, 1998). Peräkylä argued that in doing so, doctors account for their diagnosis and authority, and that this is a way of managing potential disagreement and controversy. Heath (1992a) found a similar pattern and also considered it a way of managing disagreement. We will return to Peräkylä's findings in more detail in the next chapter (Section 6.4.2) when we reflect upon physiotherapists' production of explanations for their actions. For now, it is sufficient for the purposes of the current chapter to summarise his findings as showing that doctors' provision of evidence or reasons for an assessment is a persuasive strategy which can function to accomplish congruence in situations of possible incongruence between doctors' and patients' views.

A further pattern of diagnosis production has been studied extensively by Maynard (1991a, c, 1992). The medical setting he studied involved interactions between doctors and the guardians of disabled children. He describes a recurrent sequence by which clinicians deliver their diagnosis, which constitutes 'bad news', by eliciting some form of perspective or view of the medical problem from the patient or their guardian prior to production of the clinical diagnosis. The diagnostic statement produced by the doctor in

these sequences is embedded in, i.e. it attends to and is tailored with respect to, the patient's or guardian's perspective. Aspects of the structure and function of these '*perspective display sequences*' are highly relevant to patterns seen in assessment sequences in the physiotherapy data, and we will therefore outline these here.

As with many aspects of institutional interactions, the perspective display sequence in medical interactions is an adaptation and specialisation of a practice recurrent in ordinary conversation (*c.f.* Chapter 3, Section 3.5). When people express views, opinions and assessments in ordinary conversations, sometimes, rather than stating a view outright, one party seeks their co-participant's view on the matter prior to producing their own assessment. In this way, they 'test the water' for the degree of hospitality which their own perspective will meet (Maynard, 1989). Maynard notes that this is "an inherently cautious way of approaching delivery of a report" (p109) and also that the sequence is so organised as to enable and prefer affiliation between participants' perspectives.

The sequence consists of three turns:

1. Clinician's query about the recipient's opinion – 'the perspective-display invitation'
2. Recipient's reply or assessment
3. Clinician's report or assessment

Sometimes the third part is delayed by further probes or questions from the clinician, these prompt the recipient to elaborate their reply. For the

sequence to be accomplished, it is necessary for the client or patient to provide their perspective, and this depends on their willingness to do so and on their access to knowledge (Pomerantz, 1984a). In the medical setting, perspective display sequences involve a social organisation of talk in which (as in much ordinary interaction), participants structure assessments in such a way as to enable and preserve agreement and congruency. Part of this structuring for agreement and congruency entails the clinician's initial query, which may be 'unmarked' or 'marked' (Maynard, 1991c). Marked queries, for instance 'What do you think the problem is?' are shaped such as to identify and presume the existence of a problem of some form, and to invite a view on it. Unmarked queries, for instance 'How are things going?' do not propose and presume that there is a problem, and they allow for a greater range of topics to be included within answers. Because unmarked queries do not involve the doctor initially stating any presumption about the presence or nature of the problem, they allow for avoidance of explicit disagreement. That is, since the clinician has specified no particular position, whatever the patient's response in the second turn, it cannot be explicitly disagreeing. Also, in a sequence initiated with an unmarked query, the clinician has greater flexibility in the sort of response they can produce and tailor to the patient's view. However, unmarked queries can result in longer sequences, and a more roundabout arrival at delivery of the diagnosis because they do not necessarily result in talk immediately directed to the nature of the problem.

The perspective display sequence forms an interactional strategy or resource that serves several functions (Maynard, 1991c, 1992). By producing an environment in which the patient's view is exposed, it allows for persuasion by the clinician. Thus it can be used to facilitate agreement and alignment between patients and clinicians. Specifically, patients' views can be brought towards alignment with those of the clinician. First, the clinician can encourage a particular form of patient expression of their perspective through the formulation of their initial query and any subsequent probes. Second, at production of diagnosis the clinician can shape their statement so as to align in some way with the patient's expressed view. Because it allows the diagnostic evaluation to be specifically sensitive to the patient's expressed view, because it tends to produce alignment, the sequence can be employed to reduce or avoid patients' expression of opposition or of negative affect such as distress. A further interactional function of this sequence is that in seeking patients' views, clinicians treat them as knowledgeable and indicate attention to their views. Maynard also found that perspective display sequences were closely associated with proposals for treatment plans and with justifications of clinic activities. Thus, accomplishing agreement about the doctor's assessment (the 'bad news') provides a basis for justifying the medical work that has preceded diagnostic assessment, and for what is being proposed as a remedy. Indeed, Maynard observed that the clinician's statement of the diagnosis can be so shaped as to project a particular treatment. We will observe all these features of perspective display sequences within the physiotherapy data.

Having examined *assessment* production across several institutional settings, the final part of this section raises further points about the conduct of *repairs* in these settings. Earlier, we discussed why the degree of directness with which negative assessments are produced varies between doctor patient encounters and settings such as classrooms and counselling/therapy sessions. Besides assessments, there is also considerable variation in the directness with which repairs and remedies are performed. For instance, doctors often produce treatment proposals in a direct manner (Heath, 1992a); and orchestral conductors seem to produce direct criticisms and repairs of players during rehearsals (Weeks, 1996). On the other hand, teachers repair students' 'wrong' answers in subtle ways with clues, prompts and pauses (McHoul, 1985; Hindmarsh, 1992), and speech therapists avoid bringing patients' incompetence of language to the interactional surface through repairs (Booth and Perkins, 1999). One factor that may contribute to these differences is suggested by Jones and Beach (1995), who noted psychotherapists' delicate dealings with clients in the family therapy sessions they studied, and commented on a contrast with other organisational settings such as law courts, where judges' instructions and responses are blunt and explicit. They observed that besides differences in legal power over clients, "judges do not depend on the cooperation of the people before them to the same degree as therapists and facilitators and are not attempting to build possible long-term working relationships with them." (p65-66). That is, they argue that where there is a need to foster participation and enlist co-operation, delicate handling of clients' responses may be most appropriate and effective in achieving

organisational tasks. As we noted, doctors 'repairs', i.e. their treatment proposals, are not always so delicately handled as those of teachers and therapists. This may be because although doctors need a degree of co-operation from patients, the participation and co-operation therapists and counsellors need is arguably greater, particularly because participation in treatments prescribed by doctors usually go on in settings distant to the consultation itself. Participation in counselling and physiotherapy treatment must occur to a greater degree within the session itself. The need for 'on-site' participation and co-operation may in part explain the greater delicacy and indirectness in therapists' and teachers' assessments.

Further explanation for the predominance of delicate management of assessments and repairs in some settings may concern the avoidance of displays of opposition and/or distress by patients, students or clients. We noted that some professionals such as counsellors and teachers are regularly more tentative in their corrections and repairs, and that doctors too have been found to be more tentative particularly where there is apparent or expectable incongruence between the clinical and patient perspectives. In these settings, opposition by the client and expressions of their distress is interactionally problematic and consequential in a way it is not in other settings e.g. court rooms. Physiotherapy depends on the alignment, participation and co-operation of patients, and we can thus expect therapists to assess and repair patients' 'incorrect' responses in a delicate manner.

5.2.5 Summary: assessments and repairs in ordinary conversation and institutional contexts

Routinely in social interactions, overt disagreements and negative assessments such as direct criticism of one's co-participant are dispreferred and recurrently avoided, minimised or downplayed. Repairs are also subject to a recurrent preference organisation whereby direct repairs of other's errors are dispreferred. However, in institutional settings, the tasks and goals at hand may oblige one party to produce negative, critical evaluations of another. Furthermore, in these settings proposing repairs and remedies is often a crucial part of fulfilling institutional tasks. Therefore, compared to ordinary conversations, more direct assessments and repairs/remedies might be expected. In some situations such as doctor patient interactions, this is indeed the case. However, sometimes in doctor patient interactions (particularly where patients may disagree or be distressed by diagnoses), and routinely in other situations such as classrooms and therapy/counselling sessions, assessments and repairs are done in ways that are indirect, 'gentle' and delicate. These delicate assessments and repairs entail turns and sequences that avoid explicit disconfirmation and criticism, and avoid direct exposure of the patient/student/client's incompetence. Generally these allow building of alignment and solidarity between professional and 'lay' participant.

Having outlined patterns by which individuals praise, criticise, and correct one another in ordinary conversations and institutional settings, we now turn to data extracts to examine patients' and physiotherapists' practices and

consider how these relate to the recurrent practices and preferences described above.

5.3 *Data analysis: assessments of successful performance*

In the following analysis, we will see that it is mainly therapists who produce positive assessments of performance, with patients acknowledging rather than initiating assessments. Patients usually show agreement with a nod or a brief 'yes', or greet the assessment as good news. They do not usually produce second assessments, and in their responses they do not indicate independent knowledge or evaluation, nor authority to assess their own performance.

We turn first to some of the instruction-response sequences analysed in the previous chapter. Through these we will see that during treatment activities, therapists regularly and frequently produce brief positive assessments: 'good', 'lovely' etc. The two examples that follow illustrate patterns of conduct that are recurrent throughout the data where positive assessments of patients' performance occur.

S3Ph4PaMT1/1.41

(Volume 2, pages 1-10, and Chapter 4)

The patient is lying on the bed. The therapist supports his affected arm, raising it. The therapist repeatedly guides / assists the patient in reaching the arm upwards, so that elbow straightens and shoulder pushes upwards, i.e. 'protracts' (Framegrab 5a).



Framegrab 5a (Protraction)

87-102, simplified

- 87 T an again (be so it's a) pushing you lift up
88 P *tenses body and face, appears to participate
in the arm movement*
- 90 T that's lovely
P hh
P *relaxes*
(1)
T and jus let it go
(2)
102 T an again

At the start of this extract, a three-part sequence is evident: therapist instruction (87), patient physical response (88), and therapist evaluation (90). The therapist's glossed assessment: **that's lovely** is explicitly positive and overlaps with the ongoing physical response. The patient acknowledges this with an out-breath, and relaxes his efforts. He thus treats the therapist's assessment as indicating that the activity has been achieved and completed. After the evaluation and the acknowledgement, the therapist produces a further instruction, and the activity is repeated. This is similar to the sequential organisation

- Question
- Answer
- Comment/evaluation + Further question

described by McHoul (1985) in his research on classroom settings.

In the next sequence, involving a different therapist and patient pair, the patient is trying to stand up from a seated position on the treatment bed. As

the extract starts, the therapist is giving a little physical assistance with her hand placed behind the patient's affected hip.

S1Ph1PaBT2/11.08

(Volume 2, pages 11-18, and Chapter 4)

143-165, *simplified*

- 143 T go on you can do it (.) there yer go
P *ascending towards standing up*

(0.3)

T *takes hand off patient's buttock*
looks more towards patient's face
T O↑K (.) love↑ly
P *is stood up*

P =good
P *slight eyebrow raise, looking forward*
- 157 T =yeah that felt al↑right {there's} no leaning to me>so that's
P {yes }
- 165 T <good °hh and then do then doing exactly the rev:erse

Here again we see an encouraging instruction: **go on you can do it** during an ongoing physical response (the patient's continuing efforts to stand up). This is closely followed by an explicitly positive evaluation of achievement, **there yer go**, produced by the therapist in overlap with the patient's efforts. As the patient's movement into standing appears complete, the therapist produces a further evaluation **O↑K (.) love↑ly**. The patient's acknowledgement is a little stronger than that in the previous sequence in that she gives some verbal indication of her reception of it: **good**. As above though, the patient does not produce a second assessment of her own. This therapist elaborates on her glossed assessment in a further turn which

makes explicit the criteria by which she assessed the activity as 'lovely':
there's no leaning to me >so that's <good. Once again, a further instruction to repeat the activity follows the therapist's evaluation (165).

In these extracts, as recurrently in the data, therapists produced initial positive evaluations in glossed form: 'lovely'. Terms such as 'excellent', 'good' and 'well done' are often used. The second extract illustrated that in subsequent turns the therapist may elaborate on this gloss, making the criteria by which they judge the patient's performance available to the patient (what counts as good, lovely etc.). Positive evaluations indicate the therapist's judgement of performance, and are inherently encouraging. They are taken by patients as indicating that performance is complete and correct, or is moving in this direction. Therapists often follow with an instruction to perform a further action. The implication of a therapist's positive assessment is that the patient's response has been adequate, and it provides for the intelligibility of progression to a next activity or to repetition of the current one.

The following extract features a patient who implies disagreement with a therapist's positive assessment and challenges it. This is a response rarely seen in these data and throws into relief patterns of patients' conduct that are more typical. Examining the extract will elucidate how orientation to therapists' authority in assessing patients' performance is developed and maintained, and how it is reliant on collaborative work by therapist and

patient. The extract also shows how alignment between patient and therapist is treated (at least by the therapist) as something to be pursued.

S1Ph2PaCT4/11.54

(Volume 2, pages 53-54)

This patient has been undergoing rehabilitation for three and a half months. He has a left-sided stroke, and has been diagnosed with post-stroke depression. The therapist described him as 'unmotivated'. In this sequence, the patient is walking with a tripod stick (a form of walking aid) in his right hand. The therapist supports his left, affected side, assisting his left leg and foot movement. She sits on a wheeled stool. A junior physiotherapist is pushing a wheelchair behind him, ready in case he should need to sit down (Framegrab 5b, overleaf).



Framegrab 5b

2-28

2	T	↑have you got any ↑shoes ↑(patient name)
3		(.)
4	P	yes
5		(2.0)
6	J	(but his) feet are too swollen
7	T	mmhmm

8 (2.3)
 9 T (n) they don't ↑fit at the ↓moment
 10 (0.3)
 11 P pa{rd-}
 12 T {th }is is ↑excellent
 13 P ↓is ↓it
 14 (3.5)
 15 P ((sniff)) (.) are you trying to encourage me are ye
 16 (0.5)
 17 T wa- what do you think
 18 P yes
 19 (2)
 20 T normally you have two people helping you to ↓walk
 21 P do I

 22 T *gazes to patient's face, at very end of pause, lowers her head and gaze*
 23 (3.5)
 24 P well ↑one is supported by (a) ↑stick
 25 (0.2)
 26 T *bending down to reach towards patient's left foot*
 27 T yeah↑ (.) but there's still: (it's) two people ↑and a stick normally
 28 isn't it so:: ↑LEFT LEG then↑ or are you going to do your right
patient steps right leg then continues to walk with assistance

The therapist produces a positive assessment of his ongoing walking performance (12) in overlap with the patient's response to a prior question. While this location is unusual³⁰, in several respects, the therapist's positive evaluation of the patient's performance is typical: it is direct and straightforward. Also, after the initial glossed positive: **this is ↑excellent,**

³⁰. The therapist's production of overlapping talk may relate to the fact that this patient regularly does not produce answers - he is silent instead, also he regularly produces resistant, disagreeing answers. At times this therapist organises her talk so as to fill these silences and avert or end explicit disagreement – as we see later in this sequence. The therapist may be taking the 0.3 second pause that follows her question-intonated turn at line 9 about the fit of his shoes as indicating that he is not about to respond.

she elaborates the criteria by which the performance is judged³¹: **normally you have two people helping you to ↓walk** (see also line 27). Additionally, this implies not just current success, but overall progression in the patient's abilities. The therapist implies that the current performance represents progression because only one person is assisting him to walk, as opposed to the previous requirement of two to support and assist him. This implication of overall progress is a frequent element of positive evaluations elsewhere in the data.

However, the patient's response is very unusual for these data in that he implies non-alignment and disagreement. First, he responds to the therapist's **this is ↑excellent** with: **↓is ↓it**. Far more frequently in these data, patients respond to assessments in ways that indicate they are received as news (e.g. 'really?' 'good'), and generally provide for a sense that the assessment is taken as *good* news. These forms of response invite and are often followed by a reconfirmation from the clinician. But this example is different in that through the tone and form of his talk, and particularly in his subsequent utterance (15), it is apparent that the patient does not treat the assessment as good news. Further, at both lines 13 and 15, he avoids agreement, and instead appears to question the therapist's assessment. The patient explicitly questions the therapist's reasons for giving her assessment: **((sniff)) (.) are you trying to encourage me are ye**. In suggesting that the

³¹. Such elaborations are common, though this one is unusual in that it is apparently responsive to the patient's questioning. In other data, therapists produce elaborations without such questioning (e.g. S1Ph1PBT2/11.08 above).

assessment is designed to encourage him, he questions the motivation underlying it and hence implies doubt as to its truthfulness. Examining the sequence, we can see that the therapist treats him as implying doubt: after seeking elaboration of the patient's perspective, to which only a minimal response is forthcoming, the therapist's next action is to produce the grounds for her positive assessment. She explains **normally you have two people helping you to ↓walk**. The patient's response: **do I** again indicates questioning rather than agreement. During most of the relatively long pause (23) that follows, the therapist gazes at the patient (Framegrab 5b, above), indicating to him that further talk from him would be relevant (Goodwin, 1979). Towards the end of the pause, she briefly glances down, and at this point the patient upgrades his response, producing an assessment which implies a different, and disagreeing interpretation of his performance and progress. He says: **well ↑one is supported by (a) ↑stick**. The delay in utterance and the initial word 'well' mark this response as disagreeing (Pomerantz, 1984a). Although the referent of the term 'one' is difficult to discern from the transcript alone, by his tone, he appears to be referring to the fact that one side of his body is supported by a stick (rather than using the term one to refer to himself). This is the meaning that the therapist seems to make of the referent 'one' in her response at line 27. By emphasising the support of the stick on one side, he counters the therapist's implication that his walking performance is 'excellent' because he is using less support. Explicit non-alignment with the therapist's assessment through questioning and production of alternative assessments is very rare in these data. This is associated with patients' orientations not to question or

challenge the therapist's authority and judgement, as this patient evidently does.

As we have seen, the therapist's initial response to the patient's non-alignment is to pursue agreement by elaborating her assessment: providing information about the basis for her assertion. This is a generic conversational practice used when persons have different versions of events (Pomerantz, 1984b). Also, as discussed, provision of evidence is one strategy by which doctors manage incongruence between patients and themselves (Peräkylä, 1998). When it becomes evident across several turns that this patient is not going to agree, the therapist shifts the topic and the activity at hand, preventing further open dispute (Greatbatch and Dingwall, 1997). As a result, the therapist has the 'last word', as is frequent when performance is evaluated in these data. Although for most of this sequence the patient has challenged the therapist's authority in questioning and disagreeing with her evaluation, at the end of the sequence, her authority is reasserted: the patient continues to walk under her direction, i.e. he aligns with the therapist's orchestration of what is done and when it is done.

Summarising our analysis of positive assessments, these are generally produced in a direct and straightforward manner. It is nearly always therapists who instigate them. They make available the therapist's evaluation of the patient's performance, and may include elaboration of the criteria for evaluation. They also make available the reason for continuing, or for progressing to a next activity. Generally (although not invariably) in these

data, patients respond to assessments with acknowledgements rather than their own assessments, and nearly always align with the therapist's assessment: acknowledging it or treating it as good news; they rarely challenge or disagree. In these patterns, we see a mutual orientation to therapists' predominant role in producing assessments and to their authority and expertise in making judgements of performance.

5.4 *Data analysis: sequences involving assessment and management of shortcomings of performance*

Data analysis now turns to negative assessments. These tend to cause more interactional troubles than positive assessments. These troubles include display of negative affect by patients, disruption of ongoing physical activities, and failures of understanding. They are structurally more complex and therapists treat them as more delicate. Nevertheless, they are an essential part of therapy and a prerequisite for repairs of patients' movement problems, and thus for achievement of therapists' institutional tasks.

Before examining extracts, certain difficulties of analysing management of problems of performance during physiotherapy need to be mentioned. Sometimes, it can be difficult for the analyst to identify whether or not a performance is being judged as having failed. Difficulties arise in at least two circumstances: (a) where evaluations are ambiguous, and (b) where therapists produce an action - usually an instruction - that *could be* indicative of a repair, but that does not explicitly indicate any problem.

- a) When an ambiguous and glossed assessment, for instance 'OK', is given by the therapist, it is difficult to determine whether the speaker is merely *accepting* the patient's performance, or is indicating more: that it was sufficient and adequate (Beach, 1995).
- b) When a therapist gives an instruction subsequent to a performance, it is not always possible to discern whether the instruction concerns progression of an activity which was itself adequate, or whether it is produced because the therapist judges performance of the activity so far to be problematic or incorrect. This difficulty arises because therapists frequently repair problems by giving further instructions that direct the patient to change their performance of a particular activity without directly identifying the problem.

The following analysis of problem management inevitably concentrates on episodes where it can be inferred with some confidence that a problem of performance has occurred.

S2Ph3PaHT3/11.58

(Volume 2, pages 19-33)

This extract, introduced in the previous chapter (Section 4.2.1) provides a broad introduction to many elements of patients' and therapists' interactional conduct with respect to problems of patients' performance. It is a long sequence, featuring some patterns of conduct that are typical, and some that are unusual, and we will refer to it several times in the forthcoming analysis. Of course, the extract does not include examples of every form of strategy

arising in the dataset on occasions of performance failure during physiotherapy, and so we will include extracts from other sessions in order to expand our analysis. For now though, we will focus on this extract.

The patient had a relatively mild left-sided stroke sixteen days before. He described himself to the researcher as 'highly strung', and in the recorded sessions talks frequently about worries he has. Examination and treatment of the patient's arm and hand have been the primary concern of the session so far. During this extract, a series of treatment activities are performed in which the patient is asked to manipulate various objects – a beanbag, a ball, then a pencil - with his affected hand. Problems and failures of performance are apparent.

We will use this extract as a 'springboard' from which to examine therapists' and patients' conduct. For reasons of clarity we will separate to some extent description of therapists' conduct from that of patients. At the same time we will try to avoid limiting our understanding of the sequential and collaborative nature of interactions by maintaining analytic awareness of the participation of both parties.

5.4.1 Therapists' management strategies in which the problem is not named

As the extract begins, the therapist has been mobilising the patient's forearm and hand. She then stops doing so and briefly leaves the treatment cubicle, telling the patient that she is going to **get something for you te (0.8) mo:ve**

in yer hand (15). She returns with a beanbag (Framegrab 5c, below), and demonstrates a manipulation in which she rolls it over in her hand using her thumb and fingers (Framegrab 5d, overleaf). She then passes it to the patient for him to perform the activity.



Framegrab 5c



Framegrab 5d

Apart from one short sequence towards the start of the beanbag exercise, which we examine later, the therapist's management of the failures that occur during this activity and subsequently during manipulation of the ball, are indirect and in this respect exemplify patterns recurrent in the data. Indirect indication and repair of problems is manifest in various aspects of the therapist's talk, including her assessments, instructions, and her answers to the patient's questions. In the following section of the longer extract, examples of indirect assessments and repairs are seen.

87-133, simplified

- 87 P Σ °ah° can't (do)
P attempting but failing to roll the bag,
- 90 T holds beanbag's edge
91 T can't wriggle it
- 93 rolls it over within patient's hand
94 P ↑no ↑no
- T lets go of beanbag which she has been holding
points to beanbag then withdraws hand
- 97 T see if you can use your ↓thumb
- 100 T does another 'demonstration' of thumb movement,
but without the beanbag
(Framegrab 5e)
(2)
P moves thumb but this does not result in rolling the beanbag
T reaches to beanbag, touches patient's hand
demonstrates a thumb movement
- 105 T that's it (.) to move it (.) push it forwards with your thumb
P continues moving thumb on beanbag, which does not roll
T holds edge of bag,
bends a long way forwards to look at patient's fingers
(3)
T bent forwards over patient's hand
P °no::o°
T bent forwards, looks at, then manipulates
patient's thumb and fingers
(2)
- 117 T interesting
(3.5)
P does two squeezes of bean bag but does not roll it
T sits back,
touches her pockets then beanbag
P Σ °mm° °↑no (I can-) no I can't°
P still squeezing beanbag
(.)
T stands up and walks in front of patient

- 130 T haven't got a pen at the moment I'll just find something to ↑move
 (0.5) with yer thumb
 P *looking down, continues squeezes of beanbag*
- 133 (12)
 *patient continues to hold and slightly move beanbag,
 therapist walks behind patient to a cabinet on which rest
 various pieces of equipment and fetches a small ball*

As the above extract begins, the patient has begun to try to roll the beanbag over in his hand, but problems are evident both in his explicit verbalisations (e.g. 87,94) and in the therapist's bodily actions: at first holding the edge of the beanbag and rolling it over within the patient's hand (90, 93), then letting go of it and performing another demonstration of the finger and thumb movement (Framegrab 5e, overleaf). The patient's verbal report: Σ °ah° **can't (do)** is acknowledged by the therapist (91), however she does not produce a further assessment of her own. Instead she gives the patient another instruction: **see if you can use your ↓thumb** (97), which, as we have mentioned, she augments with another demonstration of the movement (100 and Framegrab 5e).



Framegrab 5e

She then produces a further instruction: **that's it (.) to move it (.) push it forwards with your thumb** (105). Although prefaced with an apparent comment on achievement, the instruction nevertheless seems directed at repair of a failing movement. This is indicated by the placement of these instructions in the midst of apparent troubles of performance, and the vocal emphasis on 'thumb'. These corrections are indirect, the therapist does not herself directly expose the problem nor confirm the patient's own exposure of it at line 87 (for instance: 'No, you're not moving your thumb enough').

Rather, she undertakes some repair that *implies* the trouble source – the thumb. Further indirect and even ambiguous references by the therapist to a performance problem and its repair can be seen: her **interesting** (117) as she bends over, gazes and moves his hand, does the work of indicating that

she is commenting on and attending to it, but makes no reference to a problem therein. Also, at line 130, which follows further displays of efforts and verbal reports of inability by the patient, the therapist stands up and briefly leaves the treatment area saying: **aven't got a pen at the moment I'll just find something to ↑move (0.5) with yer thumb.** Her talk and movement thus indicate a change to another activity is forthcoming. However, she does not indicate a reason for doing so in terms of problems of performance – she neither verbally acknowledges the patient's problem evaluations, nor produces any assessment herself. In our analysis of positive assessments, we saw that they can provide for the intelligibility of moving from one activity to a next one, and as we will see, therapists' negative assessments can also indicate reasons for changing activities (e.g. S3Ph6PaOT4/11.48, S4Ph9PaUT1/2.55 both in this chapter). This therapist's lack of participation in assessment means that the reasons why she instigates change in activity are unspoken and unavailable.

In the full extract, several activity changes are similarly unaccompanied by any assessment by the therapist of the success or failure of the prior activity. Importantly, there is some evidence that this is problematic for the patient. We will return to these activity changes and associated troubles later. For now, suffice it to say that in changing between activities this way, the therapist institutes a reparative strategy without directly indicating a problem to which the repair is directed. The therapist's instructions to the patient earlier in the sequence about using his thumb (97) follow the same pattern of repairing without exposing the problem. In the data as a whole, instructions

of this form, which we shall call ‘sub-instructions’, are frequent. These arise subsequent to initial instruction in an activity and concern the same action but often change the emphasis somewhat, i.e. they are re-specified instructions. They work towards, and usually effect repair without naming a problem nor explicitly evaluating performance. A short extract from a different session provides another example of a sub-instruction.

S3Ph4PaMT1/1.59

As this sequence begins, the patient has responded to an instruction to stand up. The therapist is kneeling in front of him on the floor.

- | | | |
|---|---|--|
| 1 | T | <i>hands are on patient's left thigh and knee, she manipulates the muscles, drawing his weight over to his left a little</i> |
| 2 | | <i>(7)</i> |
| 3 | T | OK can you bring your weight onto your <u>left</u> leg {a bit more |
| 4 | P | {Σ°hhh } |
| 5 | P | <i>begins to lean his weight towards his left</i> |

At line 3, the therapist provides further instruction (a sub-instruction) which does not state but implies a shortfall in the patient's standing – insufficient weight on the left leg. The patient's response is prompt and overlaps with the instruction: he leans to the left and exhales effortfully. In so responding, he implicitly accepts and acknowledges the therapist's evaluation of the problem and orients to (keenly) participating in its repair.

Even more tentative and indirect problem repairs by therapists are to be found in the data. In the next extract, the problem indication and reparative action are accomplished through *withholding* instructions and evaluations rather than producing them.

S1Ph2PaCT4/11.53

The patient has a left-sided stroke. He is taking some steps by leaning his right hand on the treatment bed, which supports his right side, and with the therapist assisting his left side. The therapist produces a series of instructions that are timed with and accompany her repetitive assistance of his steps with his left leg, and are interspersed with brief positive evaluations:

- | | | |
|----|---|---|
| 1 | T | <i>sits on wheeled stool at patient's left</i> |
| | | <i>her left hand is behind patient's left, affected, hip</i> |
| 2 | T | <i>past yer ↓left ↑leg</i> |
| 3 | | |
| 4 | | <i>(0.5)</i> |
| 5 | P | <i>steps his right leg further forwards</i> |
| 6 | | |
| 7 | T | <i>reaches down to his left foot with her left arm</i> |
| 8 | T | <i>that's it</i> |
| 9 | | |
| 10 | T | <i>assists patient's left foot forwards</i> |
| 11 | | <i>(1)</i> |
| 12 | | |
| 13 | T | <i>assisting left foot forwards</i> |
| 14 | T | <i>and bring this <u>right</u> ↑leg</i> |
| | | <i>((actually appears to be referring to his left leg))</i> |
| 15 | | |
| 16 | | <i>(.)</i> |
| 17 | | |
| 18 | T | <i>lets go of patient's foot and rises to more upright sitting</i> |
| 19 | T | <i>↑goo:d</i> |
| 20 | P | <i>left foot is flat on floor in front of right</i> |
| 21 | | |
| 22 | | <i>(3)</i> |
| 23 | P | <i>steps his right foot forwards</i> |
| 24 | | |
| 25 | T | <i>once patient has stepped,</i> |
| | | <i>leans and reaches down to his left leg again</i> |
| 26 | T | <i>°good°</i> |
| 27 | | |
| 28 | | <i>(6)</i> |
| | | <i>Therapist assists patient's left foot forwards then rises up</i> |
| | | <i>Patient then steps his right foot, but not past the left leg this time</i> |
| | | <i>therapist wheels her stool back, she seems to start but</i> |

then arrest a movement down to patient's left foot
at this point she very slightly head turns
and glances up to patient's face
she keeps her hand in position behind patient's hip
patient then steps right leg further forwards
 29
 30 T *looks up to patient, then leans down to his left foot*
 31 T love↑ly
 32 (.)
 33
 34 T *assists patient's left leg to step*
 35 T left ↑leg

Of particular interest to us here is the pause at line 28, during which there is an interruption of evaluations and instructions, and a pause in the repetitive body movements. It seems that the patient has failed to step his right leg past his left. Rather than directly point this out to the patient, the therapist withholds any verbal instructions or evaluations, and also withholds the body movement she has been repeatedly using to assist him. In addition, she glances very subtly at him, and at this point, he steps the right leg further forwards and the therapist immediately responds with a positive evaluation (31), and by recommencing her assistance (34).

Several issues of interest arise from these sequences. One is that this pattern of correction/repair resembles patterns seen in other settings. Physiotherapists' use of or withholding of instructions and evaluations resembles teachers' indirect disconfirmations of classroom students' answers through clueing and re-specification of questions (McHoul, 1985). Also of interest is the way that body movement plays an important role in this strategy.

In this form of management of failures of performance, in which the problem is not verbally indicated, body movements are important in providing clarification and understanding. For instance, in the case above, when the patient stopped stepping and the therapist's instructions and evaluations stopped (28), the therapist gazed at his face and, although she had wheeled back her stool and started to move as if to facilitate his left foot movement, she arrested her movement, and maintained her hands in position. This served to indicate she was waiting for some (missing) action from him. In the 'beanbag' sequence, the therapist's demonstration of the 'correct' thumb movement reinforced the sense that a repair was going on, even though the therapist did not explicitly identify an error. In the 'standing balance' extract (S3Ph4PaMT1/1.59), the movement of the therapist's hands at the patient's left thigh prefigured and guided the patient's leftward movement.

As we discussed in the previous chapter (Section 4.3), body movement can be an important resource for communicating about problems that are delicate, which it is difficult or 'inappropriate' to talk about. Thus, it is not surprising that in the physiotherapy data, body movement is often used as a resource for indicating a problem without bringing it to the verbal surface, and likewise for repairing errors in an indirect way.

Thus far, our analysis of extracts has concentrated on several indirect and even ambiguous practices utilised by therapists in the face of patients' problems. We have focused particularly on a strategy for managing and repairing problems wherein therapists instigate repair without bringing the

- 44 P like that
T well (.) { yeah sidew }
P {or like that sorry}
P *holds beanbag out in front of him in
his left fist with elbow extended*
- 51 T yeah sideways that's it
52 P *starts to turn it over by pronating forearm,
not rolling it within his hand
(Framegrabs 5f and 5g, overleaf)*
- (1.5)
- T *holds her right hand out and does a rolling movement
with fingers and thumb*
- 57 T >no no just turning it over
P *takes hold of beanbag with right hand as well as his left,
makes hesitant movements, and does not appear to be
initiating the manipulation action*
- T *reaches to take hold of beanbag*
P over
P *holding beanbag*
- 65 T *places beanbag in her left palm*
T let me show you again
P *gaze follows therapist's hands and the beanbag*
- P mm
- T *holding and looking at beanbag with her fingers out & palm up*
T so (.) keepin yer hand nice and o{pen }
P {yeah}
- T *rolls beanbag three times*
T you're just movin the the bag in {yer} hand
P {oh }
P oh yes uh
- 82 T *passes it into patient's open hand*



Framegrab 5f



Framegrab 5g

In this sequence, after demonstrating the beanbag rolling action, the therapist passes it to the patient (34). First the patient attempts to position the beanbag in his hand, and together they repair the 'wrong' position in which he initially holds it.

At lines 44-51 there is an indirect repair, which was examined in the previous chapter (Section 4.2.1). However, the next correction of the patient's actions is more direct. The patient now grasps the beanbag, and begins the exercise. But instead of mirroring the movement the therapist demonstrated, rolling it over within the hand, he turns the beanbag over by rotating his forearm, while the beanbag is held still within his fist (Framegrabs 5f and 5g).

Direct indications and repairs of patient's problems of performance are uncommon in the whole collection. This raises the question: why does it arise here? Close examination of the sequence reveals that this direct indication concerns a problem of the patient's *understanding* rather than his *performance*. Rather than attempting and failing in the demonstrated, instructed activity, this patient appears to have misunderstood the instructions altogether. It is this misunderstanding, rather than a failure of performance that is directly managed by the therapist. This suggests that the delicacy of therapist's indication and repair varies depending on the *sort of trouble* that has arisen. Throughout the rest of the extract, the patient *is* attempting to perform the activity she asked of him, but is failing to successfully achieve it. In these circumstances, the therapist manages the problems less directly. Complete misunderstanding of the instruction, and

also interruptions of performance due to complaints of pain (data not shown) are less delicately managed than failures of achievement.

Recalling our discussion of interactional conduct associated with physical incompetence (Chapter 4, Section 4.4), it was noted that bodily conduct that is incompetent is treated as potentially undermining of a person's overall, 'essential' competence, also as potentially indicating a failure to 'try hard enough'. It seems that failure to achieve treatment activities is recurrently treated as potentially indicating 'essential incompetence' and lack of effort, whereas failure to understand is not – perhaps because misunderstanding seems less likely to be due to 'lack of effort'.

That certain troubles which arise with regard to the patient's actions are delicate whilst others are not provides an illustration of how meaning is achieved through local interaction (Chapter 3, Section 3.3.2). Rather than certain troubles being automatically, by definition, more delicate, it is through participants' treatment of them that they are made so – as Silverman (1997) points out, "what is a 'delicate' matter is something that is locally produced and managed" (p216). Put more simplistically, because failure to achieve is treated as delicate, it is delicate. This principle applies more widely still, in that whether any performance is counted as a success or a failure is not an integral property of it, but is constructed in the local interactional conduct of the participants (see Heritage 1984). This local constitution of meaning is one of the factors which make prescribing and defining good practice through abstract, free-standing recommendations problematic. However, this is to

pre-empt arguments we will put forward later in this thesis. We will return to considering the extract in hand.

5.4.2 Importance of evaluations in contributing to patients' understanding of activities

So far, several extracts have illustrated ways therapists manage patients' failures of performance, and have prompted consideration of reasons underlying these forms of management. We will now elaborate our analysis by considering patients' responses to therapists' evaluations. We saw earlier that one function of positive evaluations is to make available to patients the reasons for moving from one activity to the next. We will now argue that negative evaluations have a similar function – they help provide for smooth and mutually understood change of activity (to corrective actions). We will do so through a 'negative' example from the beanbag and ball extract, where topic changes appear rather problematic. Specifically, we will examine how absence of therapist evaluations appears to cause some interactional troubles which do not arise when ongoing activities and changes between activities are accompanied by evaluations. The therapist's conduct here is unusual amongst these data in that she repeatedly avoids any reference to failures in his performance even when are very apparent. She instigates change from one activity to another without producing evaluations.

S2Ph3PaHT3/11.58

(Volume 2, pages 19-33)

The first change we will examine is from manipulation of the beanbag to manipulation of the ball. Shortly before this change, the patient's failure to manipulate the beanbag is clear, at least through his talk:

124-137, *simplified*

- 124 P Σ °mm° °↑no (I can-) no I can't°
P *still squeezing beanbag*
(.)
T haven't got a pen at the moment I'll just find something to
↑move (0.5) with yer thumb
- 133 T *walks away and fetches a small ball*
(12)
patient continues to hold and slightly move beanbag,
- 134 T *takes the beanbag out of the patient's hand*
135 P °aah°
- 137 T *sits down, demonstrates rolling the ball with her thumb*
T ri:ght just try with thi:s: (.) all I want to see really is you
T just movin it with yer thumb

The patient has produced negative evaluations. Therefore one possible interpretation of the reason for the change instigated by the therapist is that the patient is struggling to do one activity, and may have more success with an alternative one. However, this reasoning, and the therapist's view are never explicit. Instead, she leaves the treatment scene, fetches the ball, and takes the beanbag from the patient without providing any explanation in terms of the patient's performance.

As the patient attempts to manipulate the ball, further failures of performance are apparent, especially in the following sequence which starts as the therapist instructs him to change from moving the ball forwards and backwards, to moving it sideways.

210-224, simplified

- 210 T side↑ways
- 213 P (7.5)
squeezes ball, but no sideways movement occurs
- 216 P Σ°ah uh uh
- 219 T reaches to patient's thumb
P am I doin a↑righ ↑uh
- 224 T ↓ye:ah jus need to work on that (.) on that thumb
P mm

After a relatively long period (213) during which neither party speaks and the patient tries to move the ball in the way the therapist has instructed him, he verbally expresses trouble: Σ°ah uh uh, then a direct question: **am I doin a↑righ ↑uh**, to which she responds **↓ye:ah jus need to work on that (.) on that thumb**. Thus, she produces modulated and tentative talk – implying positive evaluation with her affirmative ‘yeah’, but also repair (‘jus need to’). Thus, following a visibly failing activity about which the therapist does not provide any evaluations, the patient first produces a vocalisation to which the therapist could respond verbally but does not (216), then ‘upgrades’ to a question that more strongly obliges her to produce both evaluation and reassurance (219).

Throughout the whole extract, the patient frequently indicates concerns to the therapist through direct negative verbal evaluations, vocalised indications of

troubles ('uh', 'Σaah'), sighs, and glances. However, unlike his direct question during the ball exercise above, these prompt little direct attention from the therapist in the form of response, reassurance and encouragement.

In the next sequence, we again see that a direct question results in an evaluation by the therapist. This sequence concerns the change from ball to pencil manipulation. Again it is not preceded or accompanied by any explanatory evaluation by the therapist. In fact neither patient nor therapist produce any explicit problem indication prior to the change. However, unlike the beanbag to ball change, this time the patient actively seeks an evaluation during the sequence. As we re-enter the extract, the therapist has been physically correcting the patient's activity with the ball (Framegrab 5h):



Framegrab 5h

276-296, simplified

- 276** T *turns the ball with patient also holding it,
as she does so, the ball drops to the floor
(1)*
- T *reaches down quickly to ball*
T ooh
P *looks down to ball,
still holds his hands open*
- T *gets off bed and bends to get ball*
P aah ooh dear
- T *reaching for ball*
T huh °h

(1.5)
- T *starts standing up in front of patient*
P sorry
- T *changes direction and walks away round the end of the bed*
T =s'alright let me see if I can find my (.) my pen
- T *off camera
(14)*
- T ooh five one two six ((to other therapist))
- T *returns to treatment area, holding a pencil
(6)*
- T *sits down holds pencil in front of her
in her thumb and finger tips*
T ((coughs)) this is better
- T *leans in more to patient
with the pencil held out*
- 316** P not 'avin a very good ↑time are we
P *very slight movement head movement and glance
toward therapist*
- T *looks down at pencil, still holds it out, does not look to patient
moves pencil nearer to patient
starts to roll it with thumb and fingers*
- T =no you're doin fi:ne °h >I want you <just to
T practise just movin that over {yer } fingers like {that }
321 P {yeah} {Σ°aah°}

As the therapist is correcting and demonstrating the patient's action with the ball, it accidentally drops to the floor and she moves to pick it up. At first she seems about to pass it back to the patient, whose hands remain positioned ready to recommence the prior activity. However, as she rises up to stand, she changes course, providing a (rather minimal) explanation which centres on her action, rather than that of the patient: **let me see if I can find my (.) my pen**. Neither here, nor elsewhere, before or after the change from ball to pencil exercises does she produce any specific verbal evaluation of the patient's performance with the ball. The patient's question after the therapist has returned with pencil in hand: **not 'avin a very good ↑time are we** implies his general negative evaluation. In its content, its structure: the tag 'are we', and his distressed, worried tone, he encourages a response, and indeed a reassuring one from the therapist. The therapist orients to this with a verbal reassurance **=no you're doin fi:ne °h >I want you <just to practise** However, this is brief and with her gaze and talk she maintains a focus on the topic of the activity – the pencil – rather than on interacting about the patient's performance and its shortcomings.

Interestingly, the referent of the patient's evaluation is 'the time we are having', whereas the therapist's response concerns 'how *you're* doing'. She thereby both disattends the implied inclusion of herself in the evaluation and counters the negative assessment he has made. The patient's demeanour during this part of the sequence – his downcast gaze and tone, and the therapist's response are indicative of the delicacy and dispreference for evaluating a therapist's activity, a pattern we see elsewhere in this thesis.

To summarise analysis of this sequence, the therapist treats the patient's failures of performance delicately, as is typical throughout the data. However the extent to which she is indirect is unusual: she seems to avoid attending to problems even though these are evident, producing no evaluations except when directly solicited, and producing 'unexplained' reparative actions. In this situation, the patient makes efforts to solicit some form of evaluation and reassurance from the therapist. The patient's active soliciting of an evaluation in this case adds to the evidence that *evaluations are important in contributing to patients' understanding of how they are doing within activities, aspects of why they are doing them, and to their ongoing sense of accomplishment* in physiotherapy. In the absence of evaluations by this therapist, the patient's expressions – his talk, sighs and glances – attempt to elicit these with various degrees of obligation. It seems that *the patient expects the therapist will give evaluations*, and makes this expectation evident. Furthermore, *in their absence, this patient displays distress* and a need for reassurance, showing that he infers there are indeed problems. The patient's evident interpretation that absence of direct assessments in the presence of troubles reflects the way that withheld and delayed actions are recurrently oriented to as indicating withheld or as yet unstated disagreement, criticism, rejections etc. (Heritage, 1984; and Section 5.2.2 above).

5.4.3 Therapists' management strategies in which the problem is verbalised

We now continue our analysis of the various patterns by which therapists indicate and repair patients' failures of performance. So far, we have seen that therapists occasionally bluntly and directly identify the problem, but this is rare and occurs only in particular circumstances. In general, failures of performance are dealt with indirectly. Through providing sub-instructions, and/or withholding either instructions or positive evaluations, therapists can instigate repairs without directly naming the problem. Body movement forms an important element in these repairs.

This form of repair follows the pattern which Jefferson (1987) described as embedded correction. As noted in Section 5.2.3, in this form of correction, the problem and its repair do not themselves become the interactional business at hand. The prior activities continue, and there is no opportunity for explicit discussion and explanation of the error that preceded the correction. Thus, in the strategies examined so far, since the problem is not 'on the surface', neither it nor its consequences are available as a topic for dialogue. Furthermore, neither analyst nor therapist has any indication of the patient's perspective on and understanding of the problem.

In the sequences we examine next, the strategies used take the 'exposed form' Jefferson described, so that the problem does become the topic of the interaction, and there is sequential opportunity for talk about it. Hence it can be a basis for talk about why an individual activity is being performed and for

justification for participation in therapy. Although the problem is named, we will see that this is nevertheless done in a manner that indicates delicacy and a dispreference for direct criticism of a co-participant.

Two main patterns found in the data will be described. In one, the therapist elicits some reference to the problem from the patient prior to producing her own talk about it. As discussed in Section 5.2.4, this practice of asking a co-participant for their view first is common in ordinary conversation and is used in specialised form during medical consultations (Maynard, 1991c, 1992).

The manner in which this practice functions in these physiotherapy interactions will be explored shortly. First though, we examine the other main pattern, wherein the therapist states the problem, but it is mitigated and minimised in various ways.

5.4.3.1 The therapist identifies the problem in a mitigated form

In this pattern, the therapist produces an evaluation which identifies the problem in ways that characterise dispreferred turn shapes and elements, with pauses and other delays such as giving a positive assessment first; and using terms which serve to mitigate and minimise problems, including depersonalising the referent of the problem.

S3Ph6PaOT4/11.48

The patient is lying on the treatment bed, and is performing a series of arm movements that the therapist is resisting (a technique known as proprioceptive neuromuscular facilitation). The sequence begins in the midst of an instruction/physical response sequence:

- 1 T and a↓gain so fingers ↑back wrist back and straighten yer
2 T el↓bow think about straightening yer elbow
3 (0.5)
4 T °hh and then squeeze and come down
5 (0.2)
6 T >OK <°h yer really strong now (0.2) °h he:re (.)
7 T with the ↑ben{d::}
8 P {ye}ah
9 T that's really really strong. it's more at the ↑back
10 P =yes
11 T that's it still a- a ↑liddle bit weak
12 T although it's a lot lot stronger (.) {O↑K}
13 P {()}³²
14 P ()
15 T ((*laughing*)) hm hm hm hm °h ↑so
16 (0.2)
17 T °h I want you to re↑lax the top half of yer arm
18 P mm
19 T O↑K and we're just gunna go: hh
20 (0.5)
21 T on ↑that movement

The therapist's evaluation of the patient's performance begins with a positive component prior to identifying a problem: **it's more at the ↑back that's it still a- a ↑liddle bit weak**. This negative evaluation is mitigated in several ways. These include its lexical form: 'a liddle bit', and the way it is

³². English is not this patient's first language. His talk presented some difficulties for the analyst in transcribing and the therapist can be seen during the sessions to have problems understanding some of his words.

accompanied by an indication that even though there is a problem, there is nevertheless progress: **although it's a lot lot stronger** (12). A further mitigating element can be seen in the way that the first positive assessment is personalised **yer really strong now** whereas the negative assessment that follows is not: **that's it still a- a ↑liddle bit weak**. This strategy of depersonalising a referent has been found used in other medical interactions wherein patients' problems are treated delicately by practitioners (Weijts et al., 1993). Although some of his words are inaudible, throughout the extract the patient apparently aligns, as is evident in his vocalisations, nods, smiles, and his participation in, rather than questioning of, the therapist's evaluations and actions.

As in almost all the extracts in this chapter, indicating a problem and making a case for some next treatment activity are closely linked. That is, the problem provides a basis for the intelligibility of the next actions. The therapist's verbal identification of the problem provides a reason and warrant for the remedy (see Section 5.4.4).

5.4.3.2 The therapist seeks the patient's perspective prior to her talk about the problem

The other strategy in the data by which problems are raised to the interactional surface follows the *perspective display sequence* pattern described in Section 5.2.4. In this sequence, a clinical assessment which refers directly to the problem is produced, but not until the patient's own view has been solicited. The sequence is organised such that agreement and

affiliation is preferred and facilitated (Maynard, 1991c). This pattern arises regularly in these data, with a range of complexity. We will now consider a relatively simple example.

S2Ph4PaMT1/1.56

As this sequence begins, the patient is sitting on the treatment bed. The therapist sits in front of him and raises the bed with the electric controls. As the patient stands up, a problem of performance is evident.

- 1 T pop the bed up a bit for ↑you
- 2 (1.5)
- 3 T °h make it easy↑
- 4 (1.5)
- 5 T go on then
- 6 (3)
- 7 P *patient leans forward and bottom raises off bed a short way, but then descends – at this point, therapist appears to add to her assistance at his left hip*
(Framegrab 5i, overleaf)
patient's bottom then raises off the bed and he continues to ascend towards standing
- 8
- 9 P Σmm
- 10
- 11 T *looks down at patient's legs*
- 12 (2.5)
- 13 P *reaches standing and looks down*
- 14
- 15 T *raises head to look at patient*
- 16 T right how did that ↓feel ((tone serious))
- 17 P alright when I eventually got up (.) from- from the bed y'{know}
- 18 T {yeah}
- 19 P yeah
- 20 T °h looked like you might've needed to bring yer h looked like
- 21 T you might've needed to bring yer weight a little bit further
- 22 T forwards >have a ↑sit ↓down
- 23 P mm hm
- 24 (4.5)
- 25 P *sits down*
- 26
- 27 T °good°

- 28 P $\Sigma^{\circ}hhh$
29 T alright $^{\circ}hhh$ so remember what we said about trying to bring yer
30 T shoulders forwards ...



Framegrab 5i

The patient evidently has some difficulty getting off the bed and into standing, needing a couple of attempts to do so (7), and giving a vocal indication that it is effortful (9) (Framegrab 5i). Several sequential possibilities are open to the therapist at this point. For instance she could disattend this aspect of the performance, or could produce some sort of talk referring to it. What she actually does is to provide additional physical assistance, and then seeks the patient's view on his performance after it has been completed. The therapist seeks the patient's perspective through an unmarked question – that is, a

question that does not assume the existence of a problem (Maynard, 1991c): **right how did that ↓feel**. The patient's response indicates his awareness of a problem, but does not specify the nature or cause of the difficulty he had. This response means that the therapist can introduce talk about the problem, suggest its cause (not bringing his weight far enough forward) and its associated repair, in a 'hospitable' environment - wherein the patient has indicated that in his view the performance was problematic.

By managing a shortfall in the patient's performance through a perspective display sequence the therapist is able to check whether the patient is aware of any problem, and thereafter to refer explicitly to the problem, its cause and its repair. That is, an exposed form of correction takes place. In addition, the form of the therapist's talk about the problem at lines 20-21 contains mitigating elements similar to those examined above: **looked like you might've needed to bring yer weight a little bit further forwards**.

Prefacing her account of the problem with an evidential verb, and using the term 'might've', both make her assertion less strong and bluntly authoritative (Peräkylä, 1998). The link between problem indication and remedy proposal is again evident in this sequence. At the end of it, the patient is instructed to sit down and the therapist performs a longer repair³³ (beyond the lines reproduced above).

³³. In this extract, the therapist performs a longer and more complex correction and explanation of the performance failure once the patient is sitting down, rather than in the more precarious standing position. Dialogue of any length about problems and repairs seems to require a stable position and a suspension of the physical treatment activity itself.

5.4.4 Tying problem indications to remedies and encouragement

As we have already pointed out, regularly in these data, therapists sequentially tie negative assessments to proposals of remedies in the form of other therapy activities (e.g. the extract above). More generally, within sequences in which problems are indicated and/or repaired, therapists tend through their words and tone to encourage patients to continue their efforts.

A good example comes from Extract S3Ph6PaOT4/11.48, examined above, where we can see the therapist encourages the patient in at least two ways. She notes his progress despite the problem (weakness at the back of the arm) that is being indicated, and she proposes a next activity which seems to be aimed at remediating the current weakness:

S3Ph6PaOT4/11.48

6	T	>OK <°h yer really <u>strong</u> now (0.2) °h he:re (.)
7	T	with the ↑ben{d::}
8	P	{ye}ah
9	T	that's really really strong. it's more at the ↑back
10	P	=yes
11	T	that's it still a- a ↑liddle bit weak

This is consistent with findings by Weeks (1996) concerning repair of embodied activities. His research of an orchestral conductor's repairs of players' performances found that longer repairs were only performed when the activity had been halted. In his data, the sound created by continued playing precluded anything but terse repairs during ongoing performance. In the physiotherapy data, it seems that participants orient to ongoing (challenging) physical activities as precluding attention to anything beyond brief repairs during performance.

12 T although it's a lot lot stronger (.) {O↑K}
 13 P {()}
 14 P ()
 15 T ((*laughing*)) hm hm hm hm °h ↑so
 16 (0.2)
 17 T °h I want you to re↑lax the top half of yer arm
 18 P mm
 19 T O↑K and we're just gunna go: hh
 20 (0.5)
 21 T on ↑that movement
*(holding the patient's arm, she demonstrates an exercise
 for the back of the arm where she has indicated
 there is still weakness)*

The therapist's encouraging tone is unsurprising given the potentially demotivating effect of exposing a patient's shortcomings. The closeness of problem indications to proposals of remedies is also unsurprising; as was highlighted at the beginning of the chapter, many institutional activities such as teaching and therapy inherently involve both identification and repairs of errors. Maynard (1991c, 1992) found that through their interactional practices, clinicians work to ensure their problem assessments are formulated in such a way as to anticipate, project and indeed warrant particular clinical proposals. In the physiotherapy data too, it seems that proposing a remedy provides a warrant for making a negative assessment in the first place.

Once again, a 'negative example' helps illustrate this more clearly. The link between problem assessments and treatment proposals is particularly evident in some data where therapists 'skirt around' and avoid attending to 'negatives' when they lack a way to remedy a problem. We see this in the

following brief sequences from toward the start of a treatment session³⁴ with a patient who is five weeks after his stroke and has no hand movement and very little arm movement. In order to understand the implications of the following, it is important to know that if a patient does not have active hand movement by four weeks post-stroke, recovery of arm and hand movement is very unlikely (Bard and Hirschberg, 1965; Heller et al., 1987).

S2Ph4PaMT1/1.37

- | | | |
|----|---|---|
| 1 | T | any more ↑movement with yer ↓arm or <u>not</u> on Fri↓day °hh |
| 2 | P | no I don't think so |
| 3 | T | ↑no |
| 4 | P | no. |
| 5 | | (0.5) |
| 6 | P | I'm beginning to get a bit worried about it °I'll tell you° |
| 7 | T | =↑mm |
| 8 | | (1) |
| 9 | T | arms are ↑ <u>funny</u> things though |
| 10 | P | mm ((<i>sigh</i>)) |
| 11 | | (2) |
| 12 | T | can you come over towards me a bit |

The patient clearly indicates problems regarding both his ability to move his arm, and explicitly talks about his worried feelings (6). The therapist's response (7,9) is somewhat non-committal and certainly does not constitute problem assessment. She rapidly changes topic. About three minutes later,

³⁴ It should be noted that unlike most of the extracts discussed in this chapter, the following two brief sequences concern assessments about activities outside the current treatment session. They are analysed here because they include, nevertheless, a form of problem assessment by a patient, and because they shed light upon a particular interactional challenge – therapists' management of patients' apparently unresolvable failures of performance.

in response to a solicit, the patient produces a further related assessment, which he clearly shows through its tone and content to concern a trouble.

S2Ph4PaMT1/1.40

- 1 T how's this hand been?
2 (0.3)
3 P about the same ((*sounds sad/subdued*))
4 (2)
5 P I keep sort of rubbin it to try an get the↑muscles
6 P {goin} but nothin happens
7 T {yeah}
8 P *slight head shake*
9 (4)
10 T right just relax for me
11 (2)
12 T that's it (.) good man
13 (4)
14 T °h you rub cream into yer ↑hand

The therapist produces a minimal acknowledgement at line 7. While she subsequently proposes an action related to the patient's hand (rubbing cream into it – line 14 and beyond), this is not likely to remedy the lack of hand *movement* - as the therapist explains a few minutes later, the reason for doing so is: '**cause your skin's a little bit a little bit rough.**

In these extracts then, even though it is the therapist who initially raises the arm and hand as topics, she does not propose related treatment activities. It is not uncommon for a therapist to ask a patient about particular body parts or movements towards the start of a session, as occurs here. However, usually the therapist goes on to propose plans for the forthcoming session which are related to these body parts or movements (e.g.

S2Ph3PaHT3/11.44 Chapter 6 and Volume 2, and in a similar vein,

S1Ph2PaGT1/11.11 Chapter 6 and Volume 2). This therapist does not propose related plans for treatment. The therapist avoids directly attending to and assessing a problem of arm and hand movement, despite concerns the patient makes evident. Thus, in contrast to other extracts in this chapter in which remedies are proposed when problems are evident or made evident, the therapist does not propose a remedy that aims at dealing with or attempting to improve the movement about which concern has been expressed. It seems that in the light of this patient's poor prognosis for arm and hand recovery, treatment activities cannot be proposed. Problem indications are not an end in themselves, but form part of the work of justifying and warranting proposed treatment activities, and therapists only seem (willing) to produce them when a treatment proposal is being offered too.

5.4.5 Therapists' prospective management of problems through instruction format

Our analysis of sequences where problems of performance are apparent or made apparent has described various strategies by which therapists manage them. We have examined direct and indirect indication of problems. Until now, the problem management strategies examined occur *after* the event, as it were. We now turn to a form of prospective management of failures of performance whereby therapists deal with and pre-empt problems prior to any actual occurrence. This is done through the instructions they give.

In the data, two forms of pre-emptive management through instructions can be seen. In one pattern, the instruction projects the forthcoming activity as potentially difficult. Any subsequent failure has thus been accounted for to some extent, it is made understandable in the circumstances. In the other, the instruction is formulated in such a way that no endpoint or goal of an exercise is specified. As a result there is no 'publicly available' criterion by which achievement can be judged (Curley, 1998), therefore, if it occurs, failure is less likely to be apparent.

In the beanbag and ball extract, examples of the first pattern arise. For instance, towards the end of the sequence the therapist introduces the activity of manipulating a pencil as follows:

S2Ph3PaHT3/11.58

(Volume 2, pages 19-33)

320-334, *simplified*

- 320 T =no you're doin fi:ne °h >I want you <just to practise just movin
that over {yer } fingers like {that }
P {yeah } {Σ°aah°}
T see if you can manage °h s- that's quite difficult that's
T asking quite a lot of yer thumb really
T ↑mm oh: that's better ↑yeah
334 P very small movements of pencil and fingers

Thus in the very introduction of the activity the therapist notes that it is **quite difficult** and **asking quite a lot of yer thumb really**. The patient does manage some movement, and although the video-recording shows this to be very small, the therapist is able to say **that's better** ↑yeah.

An example from a different recording shows that the other pattern (i.e. no specific endpoint) also allows the therapist to produce a positive assessment, even in the face of limited physical response by the patient.

S1Ph1PaBT2/11.21

In this sequence the patient's arm, over which she has very little active control, is guided by the therapist. The patient is standing facing an adjustable height table. The therapist stands to her left, and has been mobilising the hand and positioning it so that it rests flat on the table. As the extract begins, a treatment activity of assisted sliding of the patient's hand over the table begins (Framegrab 5j).



Framegrab 5j

patient's hand and arm forwards

2	T	°hhh ↑ <u>right</u> >what I ↑ <u>wanted</u> to do is just see if
3	P	<i>arm starts to move forward</i>
4		
5	T	we can work on (.) ↑ <u>that's</u> ↓it
6		(4.0)
7	P	<i>arm moves back and forwards again</i>
8		
9	T	°hh that's lovely >so just watchin that
10	T	<u>arm</u> so you're <u>reachin</u> it <u>for:wards</u>

The therapist's verbal instruction (2-3) is incomplete and ambiguous – she does not specify what it is that is to be worked on. The activity appears to be guided and shaped by her physical assistance rather than her words. In the silence that follows, the patient's arm moves back then forwards again with assistance. The therapist subsequently gives a general positive evaluation, and a more specific instruction that now describes the activity: **that's lovely >so just watchin that arm so you're reachin it for:wards**. By not initially describing the aim or endpoint of this exercise, it remains open to the therapist to positively evaluate the patient's performance, whatever the result.

However, although rather vague or incomplete instructions have the advantage of facilitating a therapist's positive evaluation, not giving explicit instructions may hamper a patient's understanding of what is expected of them. In the sequence above, the patient seems able to follow and perform the activity to the therapist's satisfaction, probably due to the fact that the movement is closely guided by the therapist (Framegrab 5j, above).

However, we have seen elsewhere (S3Ph4PaMT1/2.09, Chapter 4) that such fragmentary or cut-off instructions can result in patient responses that the therapist deems incorrect. That is, incomplete instructions may fail to

establish mutual understanding. Also, in leaving the aim of an exercise unspecified, a patient's participation is necessarily limited because they must follow rather than initiate any movement.

Both the instruction forms described - avoiding specifying an endpoint, and projecting the forthcoming activity as potentially difficult – have a similar interactional consequence. This is that whatever the patient does subsequently can be treated by the therapist as successful. Thus, they can be a way of dealing with problems delicately and avoiding their exposure.

5.5 Data analysis: patients' conduct in the face of failures of performance

5.5.1 Patients' direct negative evaluations

We now return to analysis of the beanbag and ball extract to examine more closely the patient's conduct. Several aspects of his conduct are typical of episodes in the data wherein patients fail in their achievement of instructed activities. These include: production of direct negative evaluations, production of apologies, showing recognition of failure, perseverance and display of efforts at the activity despite apparent failures, and alignment with repairs instigated by the therapist.

The patient produces direct negative evaluations of his performance throughout the extract, particularly when the therapist is not directly assisting his movements – such as during his early efforts to roll the beanbag within his hand:

S2Ph3PaHT3/11.58

(Volume 2, pages 19-33)

87-94, simplified

87	P	Σ °ah° can't (do)
	T	can't wriggle it
94	P	↑no ↑no

As we have seen, towards the end of extract (and again when the therapist's 'hands are off') he produces a negative evaluation of a more general nature:

316-320, simplified

316	P	not 'avin a very good ↑time are we
320	T	=no you're doin <u>fi:ne</u> °h >I want you <just to practise ...

In this case, the therapist responds such as to reassure the patient and imply a different view to that of the patient. Therapists regularly disagree or in some way modify and account for the negative evaluations patients verbalise regarding their own performance, as can be seen in a couple of brief examples from other recorded sessions.

S1Ph1PaBT2/11.16

(Volume 2, pages 55-56)

The patient has been practising moving between sitting and standing positions, using a stool placed in front of her as a target to aim for with her clasped hands whilst ascending and descending (See Framegrab 4d in Section 4.2.1 of the previous chapter, page 135). The therapist has now removed this guiding stool, though she refers to it in line 21 below.

21-45, simplified

- 21 T ↑and then <sti:l imagine where it is there (.) ↑nice n ↓slow
P starts to descend
- (2.0)
P slowly descending
- T bending those knee:s
P slowly descending
- (5.0)
P descent slightly jerky
- 34 P I'm a ↑bit ↓wobbly
38 T =no but ↑that's ↓fine >I'm just so impressed with the con↑tr:ol
you've ↓got
(3.0)
T ↑ex↓cellent we'll ave a breather {(.) >w}e're gonna do two more
45 P {yes }

During her ongoing activity, the patient identifies a problem in a personalised and direct manner (rather than modulated, minimised etc.): **I'm a ↑bit ↓wobbly** (34). On the video, her tone is audibly apologetic. First, we notice that the patient's evaluation is produced at a time when the therapist is not guiding her movement. This corresponds with patterns we have described elsewhere: that patients' comments about performance tend to be produced when the therapist's 'hands are off' rather than when the therapist is guiding movement. The therapist directly and quickly disagrees, expressing an alternative view: **=no but ↑that's ↓fine**; and elaborating upon the criteria of this positive assessment: **I'm just so impressed with the con↑tr:ol you've ↓got**. That is, she provides reasons for her alternative and inherently encouraging view. The sequence ends with a glossed positive assessment, 'excellent' and an announced plan for the next activity, with which the patient expresses agreement.

In this extract and elsewhere, when patients initiate problem evaluations, the trajectory of the sequence that follows differs to that when therapists initiate them. In the latter, patients generally align with the therapist through physical actions and sometimes talk and they rarely produce alternative assessments. When patients initiate problem evaluations, therapists regularly disagree with and reformulate the expressed view, and produce reassuring and encouraging talk which counters the negative character of the patient's assessment. Usually, as in this extract, both parties orient to the authoritative status of the therapist's view, her alternative assessment is not challenged. Thus, when patients initiate negative evaluations, differences between patients' and therapists' perspectives surface in a way they rarely do when problem indications are therapist-initiated.

In the extract above, the patient's expressed perspective referred to her current performance as failing in some way (she was 'wobbly'). The therapist's assessment concerned the same referent (the patient herself), but emphasised and concerned success ('the control you've got'). That is, the patient 'exposed' a form of physical incompetence in her performance, and the therapist's account reformulated the performance as competent. In the previous chapter (Section 4.4), we discussed the way that exposure and reference to physical incompetence is oriented to as delicate and as having negative implications that need to be countered. In that discussion, we particularly drew upon Goffman's work (1969) in describing the 'plucky' conduct of patients and the 'compensating modes' of demeanour and action

S1Ph1PaBT2/11.15

This sequence occurs a minute prior to the previous one, the patient has been practising moving from sitting to standing. After a short rest just beforehand the therapist instructs the patient to stand again, and the sequence begins as she is rising.

1 T mm >yer ↑go > I think you just gotta keep °hh
T ex↑periencing it {have }n't yer ↓really ↑fee:ling it whad it's like
P {yeah}
T when yer bottom comes off the {↑bed } >and you feel like
P {that's it}
T >ooh crikey {I'm } only on my {two } ↑legs you ↑know
P {yeah} {yeah}
T °hh and then back ↑down a↑gain
(2.0)
25 P they've ad long enough rests aven't ↓they
P *is about half-way down at start utterance*
still slowly descending and looking forwards and down

- 28 (1.5)
- 31 T WE:LL: ↑I ↑think they've been working
as (.) °h much as they ↑can ↓do
(.)
- T {since you've had } the stroke {you} know
- P {(yes they have been)} {mm}
- P *nods, bottom is down on bed*
- 42 T {> I think } thud it's just that they °hh – the stroke
- P {mmhmm}
- T made them well wi {one } leg
- P {yeah}
- T anyway ↑wea↓ker and like you say as yer
- T having more re{sts y- y- yo}u do yer legs
- P {yeah }
- T do sort of urm °h lose their ↑strength I'm sure
(.)
- T °h b{ut } yer ↑gettin there ↑now
- P {yes}
- P good
- 66 T >yeah WE'LL DO ↑AG↓AIN and we're gonna try

The patient's evaluation that her legs have **ad long enough rests aren't** ↓**they** (25) is not personalised to the extent that patients' negative evaluations often are, and is somewhat obtuse. One reading is that the patient is implying that her performance with respect to her legs should be, or should have been better and more active than it is. This is the reading that the therapist orients to: WE:LL: ↑I ↑**think they've been working as (.) °h much as they** ↑**can** ↓**do**. Thus, after a pause (28), and initial indication that a different view is upcoming ('well'), the therapist offers a different assessment. The disagreement is softened by the prefacing of her assessment with 'I think': it is more tentative because it is formulated as an opinion rather than stated as a fact (Peräkylä, 1998). Over the next turns, the therapist accounts for the topicalised difficulties as being due to the stroke, beginning: **the stroke made them well wi one leg anyway**

↑**wea**↓**ker** (42). The therapist thus responds to a patient's negative self-evaluation by proposing that shortfalls and difficulties can be 'blamed' on the stroke (rather than for example on the patient's lack of efforts). Similar forms to this account are seen on other occasions in the data, for instance therapists sometimes propose that the patient has 'been working very hard'. This implies that the shortfall is understandable in terms of tiredness, implying that it is due to *too much* trying rather than too little. Sometimes, therapists even respond that 'I've been working you very hard', which additionally shifts blame or explanation for the shortcoming onto the therapist, and further away from the patient.

As in other similar sequences, after the initial negative evaluation, the patient in this sequence displays alignment with the therapist's assessment and account. This is evident in her nods and her talk. The therapist closes the sequence with further positive assessment **but yer** ↑**gettin there** ↑**now** and a move to the next activity

In summary, when patients produce negative assessments, therapists typically disagree with them, produce more positive evaluations, and sometimes, alternative accounts for shortcomings. This pattern reflects the general social preference for disagreement with co-participants' self-deprecations, and also a more specific orientation by therapists to 'competence issues'. That is, they respond to patients' negative assessments in ways that offset any implications that the patients' failure is

due to lack of effort and is thus wilful, or is indicative of incompetence at a personal level.

5.5.2 Patients' apologies and perseverance

Patients' direct negative evaluations of their own performance occur with some frequency in the data, but by no means on every occasion of shortfall of performance. On the other hand, when problems arise, patients almost always indicate some form of apologetic and/or concerned attitude – most commonly saying 'sorry'. Also, they recurrently convey an orientation to continuing their efforts at treatment activities in the face of problems.

Instances of apologies and perseverance are apparent in the beanbag and ball extract (S2Ph3PaHT3/11.58) we have been considering. During the patient's evident difficulties in performing the manipulative exercises, he recurrently indicates concern through his body movement, tone, and vocal expressions – sighs (e.g. 168) and 'aahs' and 'uhs' (e.g. 216, 284, 321). On two occasions his expressions are more explicit in that he uses the word 'sorry'. The first comes as he attempts to commence the beanbag rolling activity:

31-51, simplified

31	T	I want you just to turn it <u>over</u>
	P	=turn it over yes
	T	yeah {OK }
	P	{yeah}
40		(2)
	P	like that

5.6 Summary: therapists' strategies in managing patients' problems of performance in treatment activities, and patients' responses to problems

The foregoing extracts have illustrated that therapists only rarely indicate and repair shortcomings in patients' performances in a direct manner. In these data, this direct and blunt form is confined to circumstances where the patient has failed to understand, or where performance is interrupted due to pain or other obstacles. It is not used where patients attempt but fail in treatment activities as a consequence of evident physical incompetence. In these circumstances, which arise frequently in the data, therapists manage problems delicately, in mitigated or indirect ways. One of these entails therapists instituting reparative actions without actually bringing the problem to the verbal surface. This can be done through providing re-specified instructions and prompts to the patient, or, more subtly still, simply withholding instructions or positive evaluations. These repair strategies are 'embedded' in that the problem does not itself become the interactional topic, and repair is subsumed within the instruction-response sequence pattern that pervades all treatment activities whether problematic or not. They entail talk that is inexplicit so far as the nature of the problem itself is concerned, and body movement is a key resource in clarifying and accomplishing repair.

On other occasions, the problem and its correction are exposed: brought to the verbal surface of the interaction. The sequences within which this happens allow for talk about the problem and its causes, and for explicit corrections. We explored two broad forms of these sequences. In one, the

therapist produces a negative assessment which is in various ways mitigated and minimised, so that the seriousness of the problem is offset. In the other, the therapist solicits an assessment of performance from the patient prior to providing her own assessment and proposals for remedy. Across these forms of management of problems of patients' performance, therapists consistently orient to a need to encourage the patient to participate and remain motivated despite problems.

Another form of problem management is pre-emptive, it involves the formulation of instructions. Therapists may indicate within instructions that forthcoming problems are likely, because the activity that is being requested is difficult. In another form, instructions are incomplete, in that no aim or endpoint is specified. The sequential consequence of both these forms is that whatever the patient's subsequent performance, a positive evaluation can be provided. When no endpoint is specified, any shortcomings of performance will be less apparent than they would if these were measurable against an explicit aim.

Patients' responses to problems of performance and to therapists' evaluations of these were also examined. On occasion, patients produce direct negative evaluations. These self-critical assessments generally take a direct form, in contrast to the indirect turn shapes by which the therapist deal with problems. These direct negative evaluations were seen only to arise when therapists' physical guidance of patients' movement activities was minimal or absent. One particular locus for patients' negative evaluations

was when problems were very evident because of other contextual factors, but where the therapist failed to produce any evaluation herself. In these circumstances, besides producing their own evaluations, patients may also seek evaluation from the therapist, obliging them to do so with varying degrees of interactional 'force'. Whether it is the patient or the therapist who initially indicates the problem, patients consistently display an apologetic, distressed or even ashamed demeanour when problems are apparent. Also, they usually show through their talk and actions that they are consistently keen to persevere with therapeutic activity, and that they are aligning with the therapist's evaluation, and co-operating with both immediate repairs and proposals for future remedies. One element of patients' conduct seen on several occasions in the data, but not yet explored, is their reluctance to participate in evaluations of performance. This is one of several issues explored through the final extracts of this chapter.

5.7 Data analysis: troubles associated with soliciting assessments of performance

During treatment activities, therapists regularly solicit patients' assessments. Usually these concern subjective aspects – how the patient or the movement feels. It is rare for patients to provide assessments that refer to 'objective' and technical elements of their performance. We will now examine several extracts in order to explore this area.

S3Ph4PaMT1/1.41

(Volume 2, pages 1-10)

This extract was examined in the previous chapter (Section 4.2.1). After a sequence of activities in which the therapist physically assists the patient's arm movement, she solicits an assessment from him:

198-211, simplified

- 198 T how's that ↓feel: >d'you feel that (.)it's you that's doing it
T or d'you {feel it's} me
P {well I }
P I felt as though was doin a bit towards it
P any{way}
211 T {yeah}

The assessment she solicits concerns his subjective experience – his feelings about the performance.

In the next sequence, a patient has just attempted to stand up unaided, but was unsuccessful, and appeared to lose control of her affected arm as she did so. It is to this arm that the patient refers in her problem assessment (7). The therapist attempts to solicit a subjective assessment from the patient in the face of problems of performance.

S1Ph1PaBT2/11.10

- 1 T y'alright ↑there
2 P ye{ah } uh
3 T {you think-}
4 (1.5)
5 T ↑ow d you ↓feel
6 (.)
7 P that that just sh:o t back
8 P =do I {still HOLD IT (when I)} get up
9 T {OK I WOULD DO }

The orientation to subjective assessment is all the more visible here because therapist appears to change mid-utterance from a solicit concerning the patient's *thinking* to one concerning how she *feels* (lines 3 and 5 above).

The beanbag and ball extract (S2Ph3PaHT3/11.58) we have been examining also includes at its start a brief subjective assessment by the patient solicited by the therapist:

2 T ow's that feel
3 P that felt bit better (.) °h

In each of these examples, the therapist's solicit projected a subjective assessment. In the next example, the therapist's initial question projects a more 'objective' evaluation of performance from the patient – what he thinks of it (5).

S4Ph8PatQT2/10.50

1 P >was that O↑K ↓then
2 (0.2)
3 T t
4 (0.2)
5 T what do ↑you think
6 P well ↑no I'm asking your opinion
7 (0.3)
8 P I mean I don't know do I ↓really
9 T >how did you ↑find it
10 P ahem I found it hard
11 T you found it hard
12 P mm

The patient resists producing an evaluation (6-8), and only produces an assessment after the therapist has revised her solicit (9) so as to seek a subjective one – how he 'found' it rather than what he 'thought' of it.

Additionally, resistance by *both* therapist and patient to producing assessments is noticeable here. A similar pattern in another extract will be examined shortly.

The sequences above illustrate that when patients' assessments are solicited, and when they produce assessments in these circumstances, these generally concern their feelings and experience. Following on from the last of the extracts above, we now examine two further examples that include patient's expressions of disinclination either to uphold or produce their own evaluation. In the first extract, the patient produces a self-evaluation in response to a solicit by the therapist, but then attempts to retract it.

S3Ph4PaMT1/1.50

As this extract begins, the patient has moved from a lying position to sitting, and has been instructed and assisted into a position close to the edge of the treatment bed, apparently in preparation for ascending to standing from it.

- | | | |
|----|---|--|
| 1 | T | so you ↑ <u>think</u> standing ↓up yer better now aren't you |
| 2 | P | I'm sure (=of i-) a- hh su-°hh ((starts smiling)) |
| 3 | P | after sayin that (I's a mo-) heh heh heh ((doubtful tone)) |
| 4 | T | heh |
| 5 | P | °hh |
| 6 | | (0.5) |
| 7 | T | oh yee of little faith >('cause) you |
| 8 | T | think you're going to ↑ <u>fall</u> on the ↑ <u>floor</u> |
| 9 | T | <i>therapist moves down towards patient's foot</i> |
| 10 | | (5) |
| 11 | T | let's have a look at this ↓foot: Σ°hh |

The therapist solicits the patient's evaluation of his ability to stand up with a question that projects a positive response by him. The patient starts to supply this: **I'm sure (=of i-)**, but very soon stumbles, becomes hesitant and appears to try to retract his assertion: **after sayin that ...** (3). The therapist certainly orients to him as making a retraction, and in her talk suggests that this is inappropriate – that he lacks faith, and she uses an extreme case formulation (Pomerantz, 1986) – falling on the floor – perhaps to suggest this is ridiculous. She then changes topic to a next treatment activity.

This patient's retraction can be understood by reference to the recurrent orientation to avoiding exposing incompetence which has been considered several times throughout this chapter and Chapter 4. At the start of the sequence, the patient implies a self-evaluation that his standing up ability is better, indeed that he is sure of this. This puts him in a position wherein if he subsequently fails to achieve the movement, this will imply that his cognitive judgements as well as his physical response are incompetent. Our argument here is that asking for a patients' evaluation can be seen to call upon and even 'test' their cognitive competence, just as requests to perform movements call upon and test physical competence. Just as physical failures can imply incompetence, so can answers that prove 'wrong'. This may contribute to patients' reluctance to self-evaluate.

In other sequences, another factor that can be seen to contribute to patients' reluctance to participate in evaluations of performance is their orientation to the therapist's authority, and to the differential status of their judgements and knowledge. This can be seen in the following extract, which includes an attempt by a therapist to solicit a patient's self-evaluation. The patient resists doing so, and accounts for this. This accounting makes aspects of his orientations to the therapist's authority and to his own capacities and role unusually explicit. As with most extracts examined in this chapter, this one involves a form of problem evaluation and repair. Unusually, (though see S4Ph8PatQT2/10.50 above), it involves resistance by both therapist and patient to production of evaluations. Therapist resistance to a patient's solicitation of their evaluation is unusual, occurring on only three or four other occasions in these data. The sequence also provides further illustration of an (attempted) perspective display sequence and of therapists' mitigated/minimised problem indications.

S4Ph9PaUT1/2.55

(Volume 2, pages 61-64)

This sequence comes towards the end of a treatment session. The patient had his stroke three weeks before, but has had little treatment because of a chest infection. During the previous session, three therapists had been required to support and move the patient. In this session he has needed less assistance. Nevertheless, besides the senior therapist and the patient, a

junior and an assistant are present³⁵. The sequence begins after a treatment activity involving sitting balance has ended. The patient has had a fit of coughing and his breathing has just settled again as we enter the extract:

13-92

- 13 T >ave you ad en↓ough
 14 (0.3)
 15 P no: >I'm not bothered ((*flat tone*)) (0.2) 'sup to you entire↑ly
 16 (0.3)
 17 T no it's ↓no:t (0.2) doesn matter to ↑u:s (up to) you
 18 P ↓m↑m
 19 (1.0)
 20 P ohw
 21 P (think you)
 22 (.)
 23 P (think) you achieved some↑thing
 24 T ↑ d'you think you achieved {some↑thing}
 25 A {°yeah° }
 26 (1.0)
 27 P °h not up to me it's up to you
 28 (.)
 29 T {hhhhh }
 30 P {teacher}
 31 T hh uh huh \$the tea:↓cher\$
 32 T °hh ↓n:o:
 33 (0.3)
 34 T °h s' what ↑you want you gotta get better {aven't} you
 35 P {°ahh°}
 36 T {↑yeah}

³⁵. In contrast to most of the data analysed here, this is a multiparty interaction. These have been avoided on the whole, as they are very complex and their analysis raises different issues. However, this extract has been included because it is a rare instance of a particular occurrence, also although a couple of similar instances occurred during two-party interactions, these were less rich or clear examples. The analysis discussed here will focus on the primary treating therapist and the patient. However, the interactional conduct of the junior therapist and assistant was closely inspected to ensure that any conduct relevant to this analysis was not missed.

37 P {(no) } but I can- I don't know ↑what's ↑be↓tter
 38 T > ↓alright (.) ↑well to be able to sit was your ↑fi:rst ↓goal
 39 P ye{:s }
 40 T {and} you ach↑ieved it
 41 P yes
 42 T so you 'ave↑ achieved something
 43 P (I've) achieved something °y {es° }
 44 T {↑ye:}ah:
 45 (0.5)
 46 P mm
 47 T very good
 48 (0.2)
 49 T <uh: m still sometimes (0.2) (patient name) (.) you're (.) you
 are falling this way
 50 P =yes I know
 51 T so we just need to perfect it a ↑little bit more so that you don't
 ↓fall >you can ↑sit all con- con↑sistently right
 52 P mm
 53 T ↑ye:ah
 54 (0.2)
 55 T in a session
 56 P yeahp
 57 T without falling say > I mean we ↑should (a) count 'ow many
 times you lost yer balance say
 58 P yeah
 59 T probably been about five (.) and you aim for n- ↑no ↓times
 losin' yer balance
 60 P ↓mm
 61 T 'ave you ad enough in 'ere today
 62 P yes °thank you°

22 lines omitted in which the therapist, junior and to a degree the
 patient, talk about the higher level of assistance he needed during the
 previous treatment

84 T =but {we } ↓don't need ↑three
 85 P {mm}
 86 J {ho no not at all}
 87 T {\$he he hmm \$}
 88 P °ah hm°
 89 T so you ↑must be better
 90 P must be better °hh hu hum
 91 J yeah
 92 T try and keep yer...
 ((instructions follow as the patient is assisted to get dressed))

At the start of this sequence (13), the therapist asks a question of the patient that suggests and proposes ending the session. The patient responds in such a way as to place the choice of ending the session on the therapist rather than himself. At line 17 the therapist counters this. In the context of this proposed ending, the patient then asks the therapist for an evaluation of the session in terms of what she (or possibly she and the other therapists) have achieved: **(think) you achieved some↑thing** (23). In this he implies a view of the session as something in which the achievements are those of the therapist(s) rather than himself. The therapist resists responding, immediately turning back the question, but reformulating it so as to seek a self-evaluation by the patient: **↑d'you think you achieved some↑thing** (24). This is in turn resisted by the patient in a way that also offers an account for his reluctance to evaluate: **not up to me it's up to you (.) teacher** (27-30). He implies that the therapist is the teacher and thus that it is her role to evaluate his performance, not his. This account indicates a view of the therapist as having authority to evaluate, and himself as lacking ability to do so. The therapist disagrees, and accounts for this by emphasising the importance of the patient's role in the process: **↑no (0.3) °h s' what ↑you want you gotta get better aven't you** (32-34). This provides an opportunity for the patient to elaborate on his account, and formulate a specific reason why he cannot evaluate: **(no) but I can- I don't know ↑what's ↑be↓tter** (37). The therapist accepts this account, that is, she attends to and responds to it, rather than continuing to pursue an answer to her original question.

Over the sub-sequence that follows (38-44) the therapist builds agreement incrementally through a device of ‘checking out’ and gaining agreement with the facts one by one. This has been found in previous CA research to occur in circumstances where participants have different versions of events: the stepwise pattern of gaining agreement can function to place the recipient in a position of being “unable to deny convincingly or disclaim knowledge of the facts as presented” (Pomerantz, 1984b, p162). Thus the therapist here ‘forces’ agreement³⁶. Additionally, as in other instances of actual or potential disagreement about a clinical assessment, the therapist provides information about the criteria by which she evaluates the patient’s achievements.

At this point, i.e. some way into the sequence and in an environment of alignment, the therapist produces a criticism of the patient’s performance (49). In several respects this negative evaluation is typical: it is in mitigated form: **sometimes, a bit**; and is sequentially tied to a treatment plan or remedy. The patient aligns with both the problem statements and the plan relatively strongly (50), and shows attention and agreement through his gaze, nods, and vocalisations.

In this extract then, we see elements of two previously described forms of practices by which therapists manage patients’ failures. She begins a perspective display sequence (24) in a context wherein she will later produce

³⁶. This data extract is the one referred to in Chapter 3 (Section 3.8) with regard to a therapist observer regarding what he saw in it as ‘bullying’ of the patient by the therapist. We refer to it again in Chapter 7 (Section 7.3.2).

a problem indication. However, the sequence is not completed because the patient resists producing his perspective, and subsequently a different strategy is evident: the therapist produces a problem indication in a mitigated, good news / bad news format.

This extract provides more explicit evidence than most about the patient's guiding orientations. He directly accounts for his resistance to evaluating in terms of an orientation both to the therapist's differential role and authority: **not up to me it's up to you (.) teacher**, and to his insufficient knowledge: **I don't know what's better**. This provides clear evidence of patients' orientation to their lack of authority to evaluate, and to the role of the therapist in doing so. The extract also illustrates that patients' reluctance to produce self-evaluations can disrupt perspective display sequences³⁷.

In the two extracts above, patients showed some form of hesitation or resistance to providing evaluations of their own performance. The patient in the first extract seemed thereby to orient to the way that producing a verbal

³⁷. In his substantial research on perspective display sequences in medical interactions, Maynard (1991a, 1992, and Personal communication) did not find instances where recipients resisted production of their own evaluation. This may be explainable in terms of the setting he studied, where the lay participants were parents of disabled children. For parents, failing to display a perspective on their child would reflect badly upon their parenthood. Their consistent willingness to produce some view, even if disagreeing, is therefore unsurprising. The different circumstances of physiotherapy, specifically patients' reluctance to provide assessment, create different contingencies and problems for perspective display sequence use.

self-evaluation risked exposing incompetence. In the second, the patient makes his reasons more explicit, referring to the 'teacher' role of the therapist, and to his own lack of knowledge of the criteria for judging performance.

5.8 Comparison between observed orientations and practices and published recommendations for good communication practice, and explanatory analysis of observed practices

We will now examine the relationship between the patterns of conduct described in this chapter and various elements of the published recommendations for good practice. We will then develop analysis so as to seek to explain why therapists and patients act as they do, shedding light upon why actual practice conduct may conflict with recommendations by reflecting upon previous sociological analyses of the organisation of conduct. Finally within this section, we will re-examine certain strategies that seem to function in ways that meet at least some of the recommendations for good practice and are also compatible to recurrent social orientations

First, we will briefly summarise our findings of conduct and practices in interactions about success and failure of performance, therapists produce more evaluations than do patients. They produce direct, positive evaluations during and following the majority of treatment activities. Often these evaluations are glossed e.g. 'good' 'brilliant'. They are usually followed by repetition of the prior activity or progression to a next one. Therapists also produce negative evaluations. These tend to be very differently 'shaped' in

comparison to positive ones. They are produced or implied through indirect and mitigated means. Nearly always, an evaluation that makes an error of movement apparent is followed by performance or proposal of reparative treatment actions. Negative evaluations are often closely linked to various forms of encouragement of patients by therapists.

Patients generally respond to rather than initiate positive evaluations. Their responses are usually brief acknowledgements and/or agreements. They generally align with therapists' assessments and rarely challenge them. Sometimes, patients produce negative evaluations. When they do so, these are usually more direct than those made by therapists. Once a problem has been made apparent, whether by patient or therapist, patients typically produce some sort of apology. Alongside apologies, they usually show co-operative participation with immediate reparative actions and display acceptance of proposed remedies. Quite often, assessments are solicited from patients by therapists. Patients often show reluctance to provide direct evaluations of their performance. Instead, their responses tend to be restricted to reports about the experience of the activity rather than their judgement of its success or failure.

The ways patients and therapists communicate about success and failure of performance are relevant to several elements of the recommendations.

These include:

- Encouragement of patients' 'full' involvement and 'mutual participation' in therapy and in therapeutic decisions

- Minimising patients' dependence on the therapist
- Providing them with relevant information in forms that are honest and unambiguous
- Checking patients' understanding
- Avoiding treating patients as 'idiots or children'
- Promoting patients' motivation

(See Chapter 2, Section 2.1.2)

When patients' responses to therapists' instructions were examined in the previous chapter, it was shown that patients' involvement tended to be restricted to following rather than instigating activities. In this chapter, analysis has shown that patients more often respond to than initiate evaluations and repairs, and often (though not always) show reluctance to produce evaluations of their own performance. They seem dependent on therapists' judgements of their performance, and show considerable reluctance to producing independent assessments. That is, patients' participation in evaluating success and failure of performance and also in repairing failures is relatively limited. This represents a constraint upon the recommended mutual participation and 'full' patient involvement.

The recommendations that therapists should communicate clearly, honestly and unambiguously contrast with the conduct we have observed where therapists recurrently use indirect and often ambiguous means to pre-empt, indicate and repair shortcomings of patients' performance. On the other hand, their delicate management of negative evaluations, problem indications

and repairs are in keeping with the recommendations that patients are treated with respect and not as incompetent or incapable. Nevertheless, the indirect way in which therapists deal with problems has the potential to lead to ambiguity which is discrepant with recommendations for clarity and honesty in communication. Also, the 'embedded' form of problem management, where therapists institute repairs without directly bringing problems of performance to the interactional surface, is associated with a lack of direct talk about the problem, and this precludes actions by therapists to check patients' understandings.

Thus there are discrepancies between actual conduct and that suggested by the recommendations. While this raises questions about the practical feasibility of implementing the recommendations, and about the compatibility of recommendations with each other, we leave discussion of these issues to our final chapter. For now, we turn to explanations for why patients and therapists behave as they do.

We will now develop the argument that there are 'good interactional reasons' for the patterns of conduct observed, even where these are inconsistent with the recommendations, or are for other reasons puzzling.

First, a reminder of the orientations shown in the previous chapter to underlie patients' and therapists' behaviour. We noted the mutual orientation to therapists' authority to initiate and direct the treatment activities. Analysis in

that chapter also began to shed light on an orientation to dealing with patients' physical incompetence in certain recurrent ways. These involved actions by patients and therapists that serve to counter possible interpretations that physical incompetence indicates wider defects in competence, or wilful lack of effort. Through various actions, patients convey that they recognise that their conduct deviates from 'normality'. Also, that they desire and are motivated to regain normality through keen, effortful co-operation. These orientations to authority and management of incompetence and 'good patienthood' underlie the way patients co-operate with rather than question therapists' instructions.

At the start of this chapter, practices and orientations found by previous research to shape production and response to evaluations and repairs of co-participants' conduct were described. Evaluations that disagree with or criticise one's co-participant are generally performed through dispreferred turn shapes or are avoided altogether. This serves to minimise occurrence of disagreement or criticisms, and to mitigate them if they occur. We noted that one form of disagreement with a co-participant that is generally performed directly is disagreement with a co-participant's self-deprecations. Also that in ordinary conversations, when some form of performance error occurs there is a preference for self-repair, with direct correction of one's co-participant being dispreferred. The elements of patient and therapist conduct described in this chapter will now be examined so as to consider their underlying reasons and functions in the light of the points above.

5.8.1 Elements of patients' conduct

Patients *show recognition of shortcomings of performance* in various ways.

These include their facial expression and gaze e.g. raised eyebrows and glancing to the therapist; vocalised cries e.g. 'ooh'; verbal acknowledgement and agreement with therapists' problem indications e.g. 'yes I know'; or more directly through stating the problem themselves e.g. 'I'm a bit wobbly'.

Generally *they do not challenge therapists' assessments*. Also, across these various actions, they tend to show an *apologetic, sometimes ashamed or concerned demeanour*, often using the word 'sorry'. By showing knowledge of their bodily actions, and recognition that in some way these were incorrect, patients show they know what is normal, correct conduct, and what is not.

Doing so helps counter possible implications of wider incompetence because patients show they are sufficiently competent to recognise their problem.

Also, they often draw attention to the problem in such a way as to project, or at least make relevant some response by the therapist. In this, and in not challenging therapists' evaluations, they display an orientation to the therapist's authority to make judgements about the problem and to instigate repair. Their apologetic demeanour attends to showing that the problem was not intentional: it was a 'genuine' failure. Apologies also attend to the social preference for granting other's requests and to the accountability of not doing so.

At the same time as showing recognition that a problem has occurred, patients usually *display perseverance*: that they are continuing their efforts.

Furthermore, they generally do not display resignation or imply that they are

giving up or desire to do so (although see extracts involving Patient C for contrasting behaviours). They thereby show allegiance to ideas of 'normal' competence, and a desire and commitment to remedy incompetence and abnormality through effortful participation. Again, this is associated with an orientation to the therapist's authority to direct these processes, including her role as adjudicator of incompetence and competence.

Patients generally *comply with, align with, and agree with therapists' evaluations and repair* actions and proposals. Indeed, where a repair is instigated, patients show keen and prompt responses, reminiscent of those described in the previous chapter. They thereby show their commitment to making efforts to remedy incompetence, and this goes hand in hand with orientation to the therapist's expertise in determining how this should be attained. If a patient challenged the therapist, providing their own assessment and remedy, this would suggest they had sufficient knowledge and ability to have avoided failure in the first place. It would also suggest that the failure was a matter of personal choice and lack of effort, rather than being beyond their control. In contrast to practices usually seen in ordinary conversation (Pomerantz, 1984a), patients do not produce second assessments in response to therapists' assessments. This indicates orientation to therapists' authority and knowledge, and patients thereby avoid making claims to their own independent knowledge or authority to judge and evaluate performance.

Patients sometimes produce *direct negative evaluations of their own performance*. These tend to occur during activities where the therapist is providing little if any physical guidance, also where therapist evaluation might be expected. They are often personalised (e.g. 'I'm a bit wobbly') and explicitly self-critical. These serve to draw therapists' attention to problems and can oblige them to produce an evaluation. This activity is another practice by which patients show recognition of occurrence of a problem and thereby offset implications of wider incompetence. Since co-participants tend to disagree with self-deprecations, patients' negative evaluations often serve to *elicit reassurance from the therapist*. Patients may produce negative evaluations 'knowing' that this is likely to result in reassurance and/or work by the therapist to offset implications that the patient is to blame for the problem.

The fact that evaluations are not generally produced during activities physically guided or performed by the therapist seems similar to the pattern of constraint upon patients' interactional contributions during the guided and physiotherapist-performed treatment activities considered in the previous chapter. It was argued that this constraint operates because patients' comments or evaluations could be construed as undermining and questioning therapists' expertise and knowledge. Were a patient to produce a negative evaluation during a guided movement, this would in a sense evaluate the therapist's performance as well as their own, and implicitly criticise the therapist.

Patients regularly produce subjective reports and assessments in response to solicits by therapists and occasionally self-initiate these. Patients seem willing to provide information about how the treatment activity *feels*. But as we saw in data examples, on the fairly rare occasions where they are asked to evaluate success or failure, they may display *reluctance to tell the therapist what they think about their performance, how they judge it*. Patients may simply lack the knowledge to do so, as they claim in a couple of the extracts above. Certainly, most patients do not have the technical knowledge that therapists possess. On the other hand, the requested evaluations often pertain to mundane activities, such as walking or sitting upright. These are activities about which any person might be expected to be able to make some judgement, at least in general terms. Thus, there may be interactional as well as 'lack of knowledge' reasons for patients' reluctance. These relate to how withholding assessment indicates and claims a lack of sufficient knowledge to evaluate (Pomerantz, 1984a). Such claims may be implicit in the refusal itself, but sometimes patients explicitly cite lack of knowledge. Claiming lack of knowledge has certain interactional effects and functions. It constructs the patient's position and knowledge as different and lesser and thereby maintains both the therapist's authority as 'teacher' and judge of ability and competence, and the patient's role as learner. It maintains the sense of the therapy as a situation where the therapist is an expert who is teaching someone who lacks expertise; it thereby maintains the whole rationale for the therapeutic process. Another aspect of reluctance to display knowledge was also revealed by the extract in which the patient produced an evaluation to the effect that he was sure he could stand better now, but then

attempted to retract it (S3Ph4PaMT1/1.50). We argued that this extract illustrated that when a patient self-evaluates, they risk revealing cognitive incompetence 'on top of' physical incompetence. Our finding that patients' assessments and reports, whether solicited or self-initiated, are almost exclusively subjective is consistent with other studies of medical interactions. The subjective focus of patients' comments forms one of the ways that professional authority is upheld. As Maynard (1991c) explains, it contributes to mutual production of "the visibility of the distinction between lay and professional knowledge" (p179), and Heath (1992a) notes how in describing and stressing subjective elements, patients maintain "the differential status between their own understanding of the complaint and its professional assessment - between the expertise of the doctor and their own lay opinion" (p261-2). This 'differential status' is necessary to justify the patient's participation and co-operation with professional assistance.

This analysis of the constraints patients orient to in their actions illustrates the difficulties therapists can face in encouraging patients' 'full involvement' (CSP, 2000) in treatment process and choices and in minimising their dependence on the therapist.

5.8.2 Elements of therapists' conduct

We will now turn to the patterns of therapists' conduct we observed. Many elements of these *attend to patients' motivation* and to avoiding undermining it. Therefore we will briefly consider why motivation is treated as such a salient issue. Patients' failures of performance carry meanings and

implications beyond their technical causes and solutions: failures potentially undermine patients' motivation and participation, as well as therapists' authoritative status and the rationale on which therapy rests. This is because when patients fail, several interpretations of the cause and meaning of the failure are possible. One interpretation is that the therapist has asked for something that is beyond the patient's capacity, that she has therefore made a misjudgement. This could undermine the therapist's authority and expertise. Also, failure could be taken as indicating that the strategies that constitute therapy itself are not proving successful. This could undermine the rationale of patients' participation in this effortful and often uncomfortable activity. On the other hand, failures could be taken to indicate the need for *further* efforts and participation. This interpretation depends on establishing that improvement is possible and furthermore that it can be made as a result of therapy. Therefore, in order to maintain their own authority and *raison d'être*, and the rationale of the whole therapeutic process, therapists need to convey to patients and persuade them of this latter interpretation of problems. Doing so justifies continuation of therapy, and co-operative, effortful participation therein, despite the apparent problems. Thus the meaning and consequences of failures of performance are constituted through interaction. Once again, we can see that for every action different meanings are possible, and that meanings are locally constructed, and interactionally consequential (see end of Section 5.4.1).

Turning to the details of therapists' conduct, unsurprisingly they provide *frequent and direct positive evaluations* both during and following patients'

performances. Besides indicating their clinical judgement to the patient, these are inherently motivating and encouraging, often implying that progress has been made and is evident. They also project and provide reasons for repetition of activities or for a move to some next activity.

Just as in other settings, such as classroom environments (McHoul, 1985; Hindmarsh, 1992) when failures occur, more complex sequences arise. Therapists' practices in managing apparent failures of patients' performances can be pictured as occupying a continuum. At one end are very *direct indications of problems and repairs*, e.g. saying something like 'no no just turning it over' (Section 5.4.1). At the other extreme, therapists are so circumspect that they remain silent even when problems are clearly apparent, or are so ambiguous that their talk avoids any evaluative and reparative components at all. The other practices observed, and which arose with far greater frequency in the data, concern delicate management strategies that lie at various points between these two extremes.

In general, indirect methods are an effective way of avoiding direct criticism of patients, an activity that we have seen is generally avoided in both ordinary conversations and across many (though not all) institutional settings. Indirect methods mean that the negative implications of patients' failures also surface less, and require less direct attention and compensating actions. The more exposed the problem and the more obviously participants are attending to it, the more participants may treat its implications as needing countering. Unfortunately (from the analyst's point of view at least) the

present data include very few instances where patients' failures of performance are directly and bluntly pointed out by therapists and which could therefore provide evidence for this argument. Thus we must rely on speculation about what *would be* the consequences of more direct indication. It seems likely that this would cause various problems of negative affect. People avoid 'telling each other off' and recipients of 'tellings off' sometimes report feeling they are being treated like children or as stupid. Furthermore, directly indicating a problem to a patient would imply that they lacked competence to identify and recognise the problem for themselves, and thus that their incompetence went beyond the physical. Finally, making problems starkly apparent is likely to be especially demotivating.

Therapists' indirect management of shortcomings in patients' performances can be broadly divided into sequences wherein problems are not directly referred to and those wherein verbal reference to them does occur. As we observed, the first form resembles the embedded corrections described by Jefferson (1987). These, as she argued, "can be a way of doing correction-and-only-correction; of keeping such issues as incompetence and/or impropriety off the conversational surface. In effect, the embedded form provides the opportunity to correct with discretion" (p100). In the data, therapists at times *institute reparative strategies without directly naming the problem*. They do so through re-specifying or sometimes even withholding further instructions, and/or through withholding ongoing positive assessments. Through these means, therapists encourage or 'clue' patients to perform activities in different ways, and may thereby implicitly indicate that

prior performance was lacking in some way. A smooth and 'discreet' correction and progression of activity is often effected. However, this strategy does not allow for discussion of or accounting for the problem's cause. One result is that it does not provide opportunities for therapists to check patients' understandings (as is recommended) nor for patients to seek information from the therapist about the performance.

As therapists' strategies approach the end of the continuum pictured above wherein they are *so indirect as to avoid or make highly ambiguous evaluations*, we saw that patients sometimes convey that this is troublesome for them. They may show signs of distress with sighs and vocalisations, and seek the therapist's evaluation in ways that convey anxiety and concern. This illustrated that indirectness and ambiguity in this area of communication, while serving to avoid direct criticism, is a tool to be wielded with care. That is, being very indirect and ambiguous may be taken by patients as signifying unstated but very negative evaluation (Pomerantz, 1984a), and can have the same results as being very direct: display of negative affect and patients' distress.

The other form of management entails *directly naming the problem*; it becomes the interactional business at hand. This resembles the 'exposed' form of correction Jefferson (1987) described. As she argued, it provides opportunities to account for and explain problems of performance and associated remedy proposals. When management involves naming the problem, therapists either initiate and provide the problem indication

themselves (formulated so as to mitigate and/or minimise its seriousness), or they provide their problem assessment in line with, and following, an assessment from the patient.

Mitigated and minimised assessments, as with other indirect practices, allow the therapist to avoid directly criticising the patient, and thereby reduce its demotivating impact. Through them, therapists can imply reluctance to criticise patients whilst nevertheless naming the problem. Often, these assessments include positive components besides the negative ones; the therapist thereby conveys that she judges the patient as competent in some aspects, despite the negative evaluation. The therapist thus orients to reducing implications of wider defects of competence that are inherent when incompetence is exposed (Goffman, 1969). In line with this orientation, therapists also sometimes provide alternative accounts for failures. These range from elements of the formulation of the evaluation, such as depersonalising it so that, for example, the *leg* rather than the *patient* has failed, to explicit accounts for the problem which explain it in terms of the stroke, or the tiring effects of the patient's (praiseworthy) hard work.

The format and functions of *perspective display sequences*, in which the therapist invites and attends to the patient's perspective prior to production of her own, and can then tailor her assessment to the patient's displayed understanding and receptiveness have been described at length in earlier sections. Points to highlight here are that these sequences provide an opportunity for dialogue with the patient about problems whilst avoiding blunt

problem indication. They allow for building alignment and an environment of agreement in which motivated participation with remedies and repairs can be encouraged. However, we observed that patients' reluctance to self-evaluate can disrupt the running of these sequences.

A different set of strategies by which therapists deal with problems of performance concerns *pre-emptive management via the format of instructions*. Two forms seen in the data were described. These were (a) instructions that forecast problems and thereby mitigate their impact if they subsequently occur, and (b) instructions that avoid stating an aim or endpoint of the task and thereby conceal any failure to achieve this. Both allow the therapist to provide positive assessments whatever the patient's response. Because of this, they share functions in common with several of the 'retrospective' practices above. In particular, they attend to issues of patient motivation and competence by allowing the therapist to make positive comments about their performance.

Across all strategies for managing shortcomings of patients' performances, therapists *link problem indications with repairs and proposals for remedies and treatment goals*. By instigating repairs and proposing future remedies in close proximity to problem indications, therapists convey an expectation that through therapy, resolution of the problem is possible. Where no remedy is available, therapists appear reluctant to directly refer to the problem (S2Ph4PaMT1/1.37 and 1.40, above).

Across different situations, we observed therapists orienting to *pursuing alignment of the patient's view with the clinical one*. Evaluations of performance are a situation in which lack of alignment – differences in perspective – can come to the surface. This is rarely the case when therapists instigate evaluations, whether positive or negative. At these times, patients tend not to show disagreement (although this was not invariable). On the other hand, when patients instigate a negative evaluation, therapists' responses regularly disagree with these. In general, when differences of view are evident, therapists tend to pursue alignment through providing evidence in support of their assessment, and/or building stepwise agreement. These strategies aim at moving the patients' expressed view towards the clinical one, and are frequently effective in doing so. As we saw, where alignment and agreement seem not to be forthcoming, therapists tend to close down the topic and the disagreement. This is unsurprising because alignment and agreement on the nature of the problem is a prerequisite for justification of reparative strategies and for motivated participation in them

Having looked at recurrent patterns of conduct and developed explanations for why they occur, we are now in a position to examine specific practices described in this chapter and to consider how these meet the demands of both the recommendations and of broad social orientations to management of physical incompetence.

A few of the specific practices that therapists were observed to use in the management of problems of patients' performances were problematic in that

associated interactional troubles were evident. These troubles included failures of intersubjective understanding and expressions by patients that they were in some way unhappy. (Although as Maynard (1991a) points out, avoidance of patients' distress is not always in itself either desirable or feasible in medical interactions which entail talk with patients about troubles). In this chapter, ambiguity in problem identification and lack of evaluations in situations where these might be expected were a source of such troubles. We also proposed that direct and blunt problem indications and repair of failures would cause similar troubles. However, because such actions are so rare, there were no data which could be analysed to provide evidence of this.

On the other hand, such ambiguities do not consistently or inevitably result in troubles (or at least in the expression of troubles). For instance, in one extract, ambiguous 'unfinished' instructions resulted in a patient misunderstanding what was being asked, whilst in another the patient did 'follow' the instruction without apparent difficulty. Indeed, ambiguous instructions have 'positive' functions in terms of allowing therapists to be encouraging and complementary in their assessments of patients' subsequent performances, even where patients' capabilities are very limited. This illustrates that no management strategy is 'all bad' or 'all good'. Each has a variety of actual and potential interactional effects, and this means that blanket prescriptions to the effect that they should or should not be used are inappropriate, a point we will return to in the final chapter. Nevertheless, analysis showed that certain strategies can function in ways that meet at least some of the recommendations for good practice, and are also

compatible to recurrent social orientations, i.e. with the ways that people routinely behave. We will now briefly highlight these.

When therapists respond to patients' self-critical assessments with reassurance they treat them respectfully and attend to the negative affect that patients' problems tend to provoke. The delicate management strategies by which therapists indicate and repair patients' problems also have interactional advantages. For instance, instigating repairs without naming the problem is effective in quickly repairing problems with minimal disruption and without exposing and referring to the patients' failures. Practices wherein the problems are named whilst still dealing sensitively with their exposure and correction have different effects. They allow talk about problems and repairs, and thus have the potential to involve patients more in the treatment process, to provide them with relevant information, and to facilitate and check their understandings. This is the case in both mitigated/minimised problem assertions and perspective display sequences. The latter though are particularly effective in terms of their potential to increase patient involvement and dialogue. They allow for mutual participation in the identification of problems and in dialogue about them, and they involve treating the patient as having knowledge and expertise which contributes to therapy.

Therapists' frequent positive assessments can be motivating, and provide information to patients. Motivating and encouraging actions produced in close proximity to problem indications also function in keeping with the recommendations. These actions include therapists' talk about overall

progress or other areas of progress, general tone of voice, predictions of future success, and conveying an expectation of the resolution of problems. These actions help convey to patients the rationale for efforts in therapy.

5.9 Conclusion

Therapists' positive evaluations of performance success are usually brief, agreed with by patients, and form part of the process of changing from one activity to the next. When failures in performance become apparent, patients typically engage in complex interactional work. This entails displaying sufficient competence to recognise failure and its implications, but insufficient competence to have avoided failure in the first place. Through various interactional means, patients manage to convey awareness of their failures and to counter the possible implications of wider incompetence and motivated deviance (Goffman, 1969). At the same time, they convey that they are not defeated by or resigned to their failures, instead indicating a determination to continue effortful and co-operative participation in therapy.

In more specific terms, we found that patients' practices included not challenging therapists' assessments, showing an apologetic or concerned demeanour in the face of failures of performance, and displaying perseverance – that they were continuing their efforts rather than 'giving up'. Also, they show compliance, alignment and agreement not only with therapists' evaluations but also with their repair actions and proposals. In these actions, patients convey they recognise that in some way their performance was not correct, that they know (and bear allegiance to) what

are 'normal' standards of competence, and are keen to co-operate with therapists in remedying problems. Their actions also help counter possible implications of wider incompetence because they show they are sufficiently competent to recognise their problem. In addition, these actions (particularly their apologies) attended to showing that the problem was not intentional, it was a 'genuine' failure. We also saw that patients do not produce 'second assessments' in response to therapists' assessments, as per the usual pattern of ordinary conversation. In doing so they avoided making claims to their own independent knowledge or authority to judge and evaluate performance. We also noted that on occasion, particularly during activities in which the therapist was not touching the patient, patients produced direct negative evaluations of their own performance, and that these often served to elicit reassurance from the therapist.

Likewise, therapists' interactional work entails a complex balance between opposing demands: showing sensitivity to the potentially negative effects of making problems apparent whilst nevertheless attending to these problems and instituting corrective action. They do so through interactional practices that have the effect of minimising the negative implications and effects of attending to problems, which include distress, loss of alignment and demotivation. We noted that patients work to counter implications that failure results from motivated deviance and is indicative of wider incompetence. Therapists do the same, they reassure patients, minimising the problems and their implications. Sometimes this entails avoiding any direct reference to problems, at other times therapists make the problems directly apparent,

‘naming’ them, although in minimised or delicate ways. Naming problems allows for talk about their causes and about remedies. In the way therapists deal with problems, they imply an expectation that these will be solved through patients’ efforts within and alongside physiotherapy.

Our findings illustrate that several orientations are central to shaping conduct in this area of therapeutic interactions. These are:

- The maintenance of therapists’ authority and the differential between the positions and roles of therapist and patient
 - ‘Competence issues’ – specifically the avoidance of exposure of incompetence, the countering of implications that it might indicate wilful or wider incompetence, and the display of allegiance to societal conventions of normal competence
- and
- Orientations to shared social preferences and dispreferences concerning production and response to positive and critical assessments.

Our findings illustrate that current published recommendations neglect these orientations, and thus fail to allow for the requirements and contingencies of the practical work that therapists and patients do. In particular, the recommendations that therapists communicate in an open, honest, clear and unambiguous manner oversimplify the demands and constraints upon communication in this complex and delicate situation, and are potentially contradictory with other recommendations that therapists should be respectful and should maintain patients’ motivation. Establishing mutual

understanding about patients' performance, particularly where there are shortcomings, is not simply a matter of pointing out and repairing problems. For it to be successful, it is necessary to deal with problems in subtle ways that avoid distressing and demotivating patients.

In the final chapter, we will further discuss the various limitations of recommendations for good practice. We will also further discuss the role that orientations to managing physical incompetence play in shaping conduct in therapy interactions. First though, we turn to one more area of analysis of patients' and physiotherapists' conduct: interactions about reasons, purposes and goals of therapy.

CHAPTER SIX

INTERACTION CONCERNING PURPOSES AND GOALS OF THERAPY

6.1 *Introduction*

Analysis in the previous chapter showed that communication about success and failure in the performance of treatment activities is often sequentially linked to talk about reasons for doing some next or future activity. This chapter extends analysis of how therapists and patients communicate about reasons underlying physiotherapy and its activities. The importance of communication about purposes of therapeutic activities is emphasised in published recommendations for good practice, and previous research has identified that lack of communication on the topic is a source of patients' dissatisfaction.

Analysis concerns instances in the data where therapists and patients communicate about reasons, rationale, purposes, aims and goals underlying a range of actions from individual treatment activities, through sequences of activities, to participation in therapy as a whole. Interactions concerning explanations about stroke pathology and physiology are not examined. This exclusion is for reasons of feasibility and for coherence with the study's general focus on communication about treatment activities.

Part of this chapter focuses on communication about treatment-related goals. Although not a common occurrence in the data, this is of interest to analysis because goal-setting is specifically encouraged in policy and standards documents. Its relative infrequency in the data is thus all the more interesting³⁸. This is not the first study to identify infrequency of goal-setting with patients. This gives rise to the question: why, if policy so strongly encourages goal-setting with patients, is it so rarely done? Later in this chapter some answers to this question will be proposed.

6.1.1 Structure of the chapter

Before presenting and examining data extracts, relevant clinical literature is reviewed. The infrequency of communication between therapists and patients about purposes and goals contrasts with the frequency of communication on the topics analysed in previous chapters. For this reason, details about the frequency of occurrence and the special methodological considerations which result will be presented following the literature review.

Data extracts follow and are divided into two sections: a) interactions about rationale and purposes underlying therapy and its activities, and b) interactions specifically about treatment-related goals. We will draw on

³⁸. Particularly so because some therapists reported that in the presence of the camera they were conscious of trying to make their communication 'more professional', particularly by avoiding too much talk about their own social circumstances such as their family life. It is interesting that they evidently did not try to be more 'professional' by topicalising goal-setting whilst on camera.

sociological literature in order to explore reasons for the relative infrequency of these topics and to elucidate the patterns of conduct that occur when they do actually arise. In keeping with other analytic chapters, we will go on to consider the relationship between interactional practices observed and those suggested by the recommendations. The final section of the chapter re-examines practices for their 'fit' with interactional and social constraints, and with the recommendations.

6.2 *Clinical literature about communication on purposes and goals*

6.2.1 Recommendations and policy

Policy and standards documents encourage patient involvement in decision-making about therapy aims and processes. The setting of therapeutic goals is given particular emphasis. The Chartered Society of Physiotherapy's 'Core Standards' of practice (CSP, 2000) require that patients are sufficiently informed so as to be involved in decision-making, and that goals are set for each individual. The document's glossary states that goals are to be "established by negotiation", and are "Desired end points of care" which "should be realistic, [and should] include time scales that are subject to on-going review, discussion and modification". Further standards formulated for physiotherapists in neurological practice (ACPIN, 1995) state that therapists should explain their role to patients, and that goals should be "actively set with the patient" (p12), "negotiated and agreed" and "appropriate, measurable, achievable and functional" (p15). As in the CSP guidance, goals are described as time-related.

6.2.3 Defining goals³⁹

Wade, a respected authority on stroke rehabilitation who published a series of papers on goal-setting in rehabilitation (Wade, 1999a-d) points out that there is no generally agreed definition of goals. He proposes that a goal is “the state or change in state that it is hoped or intended for an intervention or course of action to achieve” (Wade, 1999c, p8). He proposes that rehabilitation goals range from long-term overarching aims, to “specific key achievements to be completed within a certain specified relatively short time” (Wade, 1999c, p8) and which usually concern uni-professional interventions. It is this latter type of goal, which Wade denotes ‘targets’ that are examined within this chapter.

6.2.4 Advantages and difficulties of goal-setting

Goal-setting is said to be central to effective rehabilitation (Lawler et al, 1999; Wade, 1999d). Advocates argue that it ensures that rehabilitation is rooted in individual patient’s requirements as opposed to professional agendas:

"It helps direct attention away from the traditional, narrow approach of medical, disease-driven concepts, to a wider problem-based perspective where the involvement of the patient becomes explicit and fundamental" (Lawler et al., 1999, p402).

³⁹. Most published literature focuses on goal-setting, rather than the more general topic of communication about reasons and purposes of therapy. Therefore the majority of this review concerns literature on goal-setting.

Goals are also said to facilitate patients' motivation and co-operation (Wade, 1999b; Moffett, 2000; Maclean and Pound, 2000), increase patients' understandings of their position and progress (Talvitie, 1996; Lawler et al., 1999), and allow clarification of the expectations and responsibilities of all those involved (Lawler et al., 1999). Wade's review of research findings concerning rehabilitation goal-setting (1999a) concluded that there is some evidence to support the claim that rehabilitation is more effective where goals are explicitly set. There is complementary evidence in the field of organisational and business management, where goal-setting is an established managerial strategy; research has found that people's conduct can be influenced in the direction of improved performance where goals are explicitly set (Kerr and Slocum, 1999). In both rehabilitation and organisational performance research, goals have been found to be most effective in influencing conduct when those involved in achieving them (i.e. patients and workers) participate in setting them (Wade, 1999a; Kerr and Slocum, 1999).

Whilst there are advantages to goal-setting in rehabilitation, the process also presents challenges. Those identified in the literature concern reconciling conflicting perspectives of clinicians and patients (Partridge, 1994; Wade, 1999b; Lawler et al., 1999) and the difficulties of predicting accurately any individual patient's prognosis (Wade, 1999b). The latter makes it hard to set goals that represent meaningful challenges rather than being "unrealistically hard with the potential to demotivate, or ... too easy to attain." (Lawler et al., 1999, p402, see similar arguments in Wade, 1999a).

6.2.5 Findings of research into communication about purposes and goals of therapy

Having discussed goal-setting specifically, we now go on to review studies which have considered occurrence and practice of both goal-setting and explanatory talk about reasons underlying therapy activities. There is however, a lack of empirical literature describing actual *processes* of explanation and goal-setting in therapy interactions (Lawler et al., 1999), and most studies to date are surveys of patients' and therapists' views rather than empirical observational studies.

Partridge (1994) examined stroke patients' views of their physiotherapeutic experiences and reproduces several vivid quotes, including:

“There's definitely not enough explanation, when they come along you need to know why they want you to co-operate”

“The physiotherapy was extremely good but there again I do wish they would say ‘Today we are going to do this, because it's going to ...’ and then explain it, the purpose of it, I'm sure they would get more co-operation if they did.”

(p31).

These findings are echoed in an analysis of video-recordings of 13 physiotherapy sessions, some with patients with neurological conditions (Talvitie, 1996), which found that the therapists “hardly ever discussed with the patients the goal of the therapy or the importance of a partial exercise in

the context of the total rehabilitation programme” (p49). Also, Parr et al’s (1997) interview study with people with stroke who had received speech and language therapy echoes these physiotherapy studies in that there was a reported failure of some therapists to explain the purpose and reasons for what is done in therapy.

Talk about goal-setting also seems to be infrequent. An interview study (Payton and Nelson, 1996) found that physiotherapy patients reported they were minimally aware or not aware at all of being asked to participate in goal-setting. The researchers noted that patients “expressed little concern for this issue” (p35). They suggest that goals of therapy were “obvious and commonly understood by these patients and their therapists” (p35); although they argue that the assumption of common understandings may be mistaken and can result in ‘dangerous deficiencies’ in treatment. A subsequent publication (Payton et al., 1998) reported that patients varied in the degree to which they wished for involvement in treatment decisions and goal-setting. Many of those interviewed expressed the view that ‘therapist knows best’, and one patient commented that if a therapist asked about goals, this indicated a lack of professional expertise. Because their study found such divergence between patients in their desire to be involved in goal-setting and decision making, Payton and colleagues argue that patients’ preferences in this area should be explicitly sought and discussed.

Another study of goal-setting, this one specific to stroke rehabilitation, considered specialist community nurses (Lawler et al., 1999). The data

consisted of interviews and documented treatment records. The nurses were found to vary in their use of goal-setting, some using it explicitly with patients, whilst others “used the concept to inform their actions whilst being less explicit and more informal” (p401). Thus, there are indications that where goal-setting does occur, practice is highly variable between clinicians.

6.2.6 Clinical literature review: summary

Policy documents and professional recommendations encourage therapists to communicate with patients about reasons underlying treatment and to set goals with all patients. Communication on these topics is said to ensure patients’ views are central to treatment decision-making, and to facilitate effective rehabilitation. There is some research evidence that explicit goal-setting increases rehabilitation effectiveness. However, several interview studies and one observation study found that goals and reasons do *not* frequently arise as topics in physiotherapeutic interactions. Commentators have identified difficulties of goal-setting. These concern setting goals at appropriate levels so as not to be demotivating, and also exposing and reconciling differing perspectives of therapists and patients. However, it seems that to date no empirical research has sought to explain the low frequency of goal-setting and explanatory talk in terms of these or other difficulties. Much of the literature assumes that goals *should* be set and that purposes *should* be explained, thus seeming to assume that this is what patients want, though one study has challenged this (Payton et al., 1998; Payton and Nelson, 1996). Most publications decry failures of communication on these topics, and assert that ‘more should be done’, but

they do not pursue explanations for 'failed' practice. This chapter will describe interactional processes entailed in explanation and goal-setting at a level of detail not previously attempted. It will seek to explain reasons for current practices (and lack thereof) in this area rather than simply adjudging practice as failing.

6.3 Frequency of interactions about reasons, purposes and goals in the data, and related methodological considerations

Topicalisation of why activities were performed or proposed occurs at some point in all the recorded sessions. However, many treatment activities within each session are instituted without any form of explicit communication about their purpose and rationale. This is consistent with the findings of Talvitie's (1996) video analysis which was referred to on page 324-325.

In the current study, setting of therapeutic goals was even less common than communication about reasons. It occurred in eight of the 74 sessions. In addition, there were ten recorded sessions in which goals were referred to but where goal-setting per se was not observed. See Tables 6a and 6b, overleaf.

Table 6a: Frequency of goal-setting episodes⁴⁰ in the recorded sessions

Number of sessions in which goal-setting occurred	Number of patients	Number of therapists	Site	Total sessions recorded per site
4	3	2	1	25
0	0	0	2	19
2	1	1	3	14
2	2	2	4	16

Table 6b: Frequency of references to goals without actual goal-setting during the recorded sessions (see footnote 3)

Number of sessions with reference to goals but not goal-setting	Number of patients	Number of therapists	Site	Total sessions recorded per site
5	3	2	1	25
0	0	0	2	19
3	2	2	3	14
3	2	3	4	16

⁴⁰. An episode was defined as goal-setting when:

(1) The word goal, aim or objective was used in the context of therapy-related activities and

(2) A physical action, task or competency was topicalised and then proposed as a 'goal' or 'aim' with a time limit put on its achievement.

Episodes fulfilling only the first of these two criteria were counted as references to goals but not goal-setting. We nevertheless acknowledge that attempting to quantify in this way presents methodological problems (Schegloff, 1993). A particular problem in this case concerns defining what counts as an episode – for instance, some episodes sounded like references to goals but the words listed in Criterion (1) were not used. However, alternative definitions would result in only a slight change in the frequency counts reported here, the overall point that this topic is rare in the data would remain unchanged.

Interactions about what is to be done in treatment (Chapter 4) and how well it is done (Chapter 5) are much more prevalent. This allowed search for and presentation of 'typical' examples of recurrent interactional practices associated with those topics. For this chapter, there were sufficient interactions about reasons and rationale to allow selection and presentation of extracts which illustrated patterns that are seen recurrently in the data. However, there was an insufficient number of interactions about goals to develop any analysis of recurrent patterns. None the less, the available data allows analysis of a range of practices and challenges that arise when goals are topicalised. Further consideration of the limitations and scope of analysis in this chapter can be found in Section 6.8.

6.4 *Data analysis: interaction about reasons, purposes and rationale*

As noted above, the majority of treatment activities in the recorded sessions are instituted without any form of explicit verbal communication about their purpose or rationale. On some, though not all of these occasions, although there is no talk about why an activity is being requested and performed, reasons for the activity would appear to be intelligible as a consequence of their sequential position. The following extract illustrates this.

S2Ph2PaHT3/11.44

(Volume 2, pages 34-39)

This extract comes towards the beginning of a treatment session. The patient was admitted to the rehabilitation ward eight days before. He had a mild stroke 16 days ago. Once the patient has been assisted to walk into the treatment room, sit on the treatment bed and remove his shirt, a physical examination commences. A minute or so before this extract, the patient complains his affected arm **still feels a bit (.) bit ↑stiff**. As we saw when we examined this extract in Chapter 4 (Section 4.2.1), the therapist examines this arm, moving it around and asking questions about it. She examines parts of the patient's arm then hand in series (Framegrabs 6a and 6b).



Framegrab 6a



Framegrab 6b

The therapist then recommences moving the whole arm around (line 52, Volume 2), asking whether the patient has any problems with his shoulder or elbow, and the patient replies no (68, below). Her physical examination actions stop at line 77 (below) when she commences manual techniques that mobilise the muscles and joints of the patient's hand. Soon afterwards she moves her whole body from the latest of a series of kneeling positions on the treatment bed to a sitting posture which she maintains for several minutes (Framegrab 6c). As she performs the mobilisations, the therapist continues a sequence of questions about the patient's activities outside therapy (the first of which is at line 85 below).

64-99, simplified

- 64 T *having been moving patient's arm back and forth, therapist comes to a stop of these movements, holding the patient's arm stretched out*
- 65 T no problems
- 68 P no
(.)
- P {no }
- T {↑no}
- T *adjusts grip on patient's hand*
(0.5)
- 77 T *mobilisations of patient's finger and thumb joints start*
T mainly the hand
- 81 T *shifts her body position, climbs off treatment bed and sits down on it, keeping hold of patient's hand and looking down at it during the move also continues the mobilisations of his thumb joints as she moves*
(2)
- 84 T *mobilising the patient's thumb and fingers for several minutes*
(Framegrab 6c, overleaf)
- 85 T °hh it's still a little bit swollen in't it- >ave you been doin
T that massa:ge that we suggested
P ye:s yes
(1.5)
- P I've been doin the finger exercise an that
- 99 T yeah

Thus, as the therapist performs the mobilisation treatment, verbal elements of examination continue, and *the therapeutic activity of mobilising is not referred to verbally in this sequence nor thereafter*. Nevertheless, the prior physical examination and talk about problems of the arm and hand provide for the intelligibility of the mobilisation treatment.



**Framegrab 6c – position adopted
during mobilisation treatment**

This sequence illustrates what frequently occurs during treatment activities in the recorded sessions: reasons underlying activities are not directly addressed through talk but may nevertheless be intelligible because of the sequential context. However, in these circumstances, whether the patient *actually* understands reasons is difficult for either analyst or therapist to determine. This is because if patients do not understand *why* an activity is done, the treatment activity is not itself disrupted except on the rare occasions when patients bring problems of understanding to the surface (as in S3Ph5PaNT2/2.25 above). This contrasts with failures of understanding about *what* is to be done which are immediately evident in a patient's physical response to an instruction (e.g. S3Ph4PaMT1/2.09, Chapter 4).

Thus, failure to understand *reasons* underlying an activity is not visible in a patient's physical conduct the way it is when there is failure to understand what is to be done. This 'invisibility' is compounded by the dispreference that we argued patients show towards asking therapists to explain reasons. It would seem reasonable to propose that without verbal communication on the topic, it is unlikely that patients always understand why an activity is being performed.

We will now examine extracts in which reasons and rationale *are* talked about. In doing so, we will identify the locations, structure and contents of interactions about reasons and rationale. It will be shown that patients themselves rarely initiate this topic, and that when they do, it is in restricted ways. We will see that there are recurrent sequential links between episodes of talk about reasons and the occurrence of various interactional and therapeutic troubles, and also between talk about reasons and interactional attention to patients' motivation. The first sequence introduces several characteristic features of these interactions.

S2Ph5PaMT1/2.13

(Volume 2, pages 65-70)

The extract comes towards the end of a session. The patient has been undergoing rehabilitation for the five weeks since onset of his left-sided stroke. He stands with a table in front of him and has been reaching up to the therapist's outstretched hand. This is a common exercise for facilitating standing balance and active leg muscle work. The activity has just ended, and the patient sits down. As he does so, he alerts the therapist to 'cracking' audible at his left knee joint⁴¹.

15-44, simplified

- 15 (3)
((audible cracks as patient sits down))
- 18 P ooh I can 'ear that crackin
P *smiling, starts this utterance before fully down*
- P °hh °hh
(1.5)
P *glances at therapist and nods*
- T *gazes down to patient's knee*
T {a↓right }
P {d' you hear} (that) crackin ↑then
P *reaches to touch his left knee*
(Framegrab 6d, overleaf)
- T *nods*
(1)
P *rubs knee*
- P °ohh°
- 41 T (an) it was your ↑right knee that used to be a problem isn' it
44 P ↑yeah yeah

⁴¹. Such noises from the knee joint are common and would not necessarily be a major cause for a therapist's concern.



Framegrab 6d. Although the view is somewhat obscured, it can be seen that the patient has reached his right hand towards his left knee.

When the therapist does not display specific attention to his utterance at line 18, he reiterates verbally and points to and rubs his knee while gazing at the therapist (Framegrab 6d). These actions are successful in getting the therapist's attention (*c.f.* Psathas, 1996): she turns her gaze to his left knee, nods and verbally acknowledges by commenting that his other knee has formerly been 'a problem' (41). This raising of a problem comes to form the basis for talk about the reasons underlying current and proposed treatment activities. Thus, after a pause during which the therapist gazes downwards and towards the left knee with a thoughtful facial expression, she produces a statement that elaborates on the problem the patient introduced:

51-99, simplified

- 51 T >°hh that's our <biggest problem walking at the moment (.)
T definitely
(1)
- 55 P snappin it back ↑yeah (.) yeah.
- 59 T an I think it's worth spending the time as- ↑as we
T ↑have been doing
- 62 P yeah getting some {erm (muscles)}
T {↑just doing } it
- 67 T even it it's ju{st (.) >si}t to stand I mean it's <↑good to ↓wa:lk
P {yeah }
- (.)
- P yeah
- 77 T °hh but we don't wanna =↑overdo it at the same ↑time
(1)
- 82 P well I'd soon(er) be able to do it ↑properly
T {yeah }
- 86 P {(tha y k}now ↑get some muscles back {(again)}
T ((louder)) {I mean}
- T you need is it is it sort of a circles > you ↑need to do it to
T be able to get the ↑muscles working but at the
- 97 T same time there's no point letting you do it wrong
- 99 P no

In his response (55) to the therapist's identification of 'our biggest problem', the patient now refers to the knee snapping back – a different problem to the knee cracking and (implied) pain which was his initial formulation. Thus he displays recognition and understanding of the therapist's version of the problem. His response indicates considerable inferential elaboration, also technical physiotherapeutic knowledge about his leg control when walking.

The therapist moves on to propose that the activities that have recently been performed ('sit to stand') are therefore appropriate and their continuation justified (59 onwards). Also, she proposes that although **it's <↑good to ↓wa:lk**, there should be some restriction of this walking. She produces

several reasons for this restriction: not overdoing it (77), not letting the patient do it wrong (97), and avoidance of knee soreness (103, below).

In his talk, the patient displays further understandings of reasons for current activities: getting some muscles back (62, 86); and for the restriction on walking: **well I'd soon(er) be able to do it ↑properly** (82). His body movements, particularly nodding, display agreement with the therapist. The sequence continues:

- | | | |
|-----|---|--|
| 103 | T | ↑more of a point that yer ↑knee'll probably get sore |
| | P | <i>looks down</i> |
| | T | if we let it <u>snap</u> around all the time |
| | P | <i>nods, unsmiling</i> |
| | T | <i>gazing at patient and nodding</i> |
| | | (3) |
| 111 | P | <i>stops nodding</i> |
| 114 | T | °h s' praps have a look at yer walkin' again to↑morrow |
| 115 | P | <i>up to therapist</i> <i>mouths OK</i> |

Thus, the topic seems to lapse and the patient looks downwards, and stops smiling and nodding (103-111). At this point the therapist indicates the prospect of walking again despite the current restriction: **praps have a look at yer walkin again tomorrow** (114). Both this proposal and the therapist's lengthy justification for currently not walking may attend to the strong desire to walk that most stroke patients express (Pound et al., 1998; Doolittle, 1992). The therapist appears to anticipate that talk about the restriction on walking may result in interactional troubles such as patient resistance or distress. Soon after this (see Volume 2) there is a co-operative ending of the

topic with both participants gazing downwards, and the patient agreeing with the therapist that he has had enough for the day (133-142).

In this sequence, talk about reasons was fairly complex and lengthy, but this is not always the case. Just before it, there is a more straightforward example of a therapist providing reasons for a proposed activity:

1-7, simplified

- 1 T ri:ght (.) d'you want to ↑hold onto you:r left arm again
T *points to patient's left hand*
- T I'm going to <move the table out of the way before you sit ↓down
P *moves to take hold of his left wrist with his right hand,
and raises his hands clear of the table*
- 7 P yeah (OK)

While this instruction does not strictly concern a physical *treatment* activity, it nevertheless illustrates a form of explanatory talk where instruction and explanation are connected within a single turn as is occasionally seen elsewhere in the data (e.g. S1Ph1PaBT2/11.08, Chapter 4). These are fairly frequent in just one or two of the recorded sessions. One further location for relatively straightforward explanations by therapists occurs in the data. Although there is not space to reproduce transcripts, there are five or six sequences where therapists introduce and explain standardised clinical tests of the patient's performance⁴². In contrast to most activities, therapists explain the functions of the test in detail when they apply it. Their talk

⁴². Specifically, the Motor Assessment Scale at Site 3, and the Ten Metre Walk Test at Sites 3 and 4.

suggests that therapists treat these tests as ‘special’ procedures for which some form of explanation *is* required; more routine treatment activities seem not to be treated in this way. As Drew and Heritage (1992) point out, professionals’ practices, and thus patterns of interaction, tend to be shaped by their view of the business at hand as routine, despite the *non-routine* nature of the activity for the patient or client.

Several elements of Extract S2Ph5PaMT1/2.13 as a whole are worth highlighting. We will group these into observations about a) location, b) structure and content, and c) functions and effects of the therapist’s and patient’s activities.

Two occasions of talk about reasons were noted. There was an example of a straightforward and ‘simple’ reason located as part of an instruction: **d’you want to ↑hold onto you:r left arm again I’m going to <move the table out of the way** (1-4), and a more complex sequence of talk about reasons that related to the patient’s knee problems and formed a justification of proposed treatment activities. This sequence reflects a broader pattern evident in the data wherein indicating physical shortcomings and formulating a rationale for proposed actions are recurrently linked, both sequentially and topically. A further characteristic feature observed in this extract was that the topic arises towards the end of a session. Both starts and ends of sessions are recurrent locations for talk about reasons and goals. Topicalisation of reasons is also sequentially related to what might be called *therapeutic troubles*: in this

sequence these concern the knee, and to possible *interactional troubles*: in this sequence these potential troubles arise from the proposed restriction of walking. As we will see in the extracts that follow, reasons and purposes are often topicalised at times of apparent or potential therapeutic and/or interactional troubles.

Moving from the location to aspects of the content and structure of the explanatory talk (who says what and in what order): this therapist introduces the topic by reformulating and elaborating on a problem first raised by the patient. More commonly in the data, it is therapists who first introduce or elicit the problem, but whichever pattern, therapists' explanatory talk is commonly problem-linked. Alternatives, such as basing explanations on more positively framed 'needs' or patients' wishes are less common.

A fairly distinctive aspect of the structure and content of talk in this extract is this patient's high degree of interactional involvement. This is seen in his problem-initiation, his display of therapy-related knowledge, and his dialogue with the therapist concerning both problem and solution. More often, patients' contribution to these interactions is limited to brief acknowledgements and agreements. This patient's involvement may reflect his relatively long experience in physiotherapy, and also his intact cognitive and perceptual abilities⁴³. Although the degree of his participation in talk about reasons underlying activities is unusual, its location is not: in that it is only produced once the therapist has initiated the topic.

Several interactional functions and consequences of conduct in this extract are worth highlighting. First, talk about reasons for *particular activities* also functions to imply aspects of rationale, purposes and aims of *therapy as a whole*. For instance the patient talks about walking ‘properly’ and the therapist about not letting him ‘do it wrong’. Ideas and assumptions that the aim of therapy is the restoration of ‘normal’ correct movement commonly arise in this way. Also, talk about overall rationale arises from talk about reasons for particular activities, rather than being raised as a separate topic.

Finally, in this extract and all the others in this chapter, communication about reasons underlying treatment activities inherently assumes the possibility of progress, i.e. resolution of particular or general physical shortcomings. Further, it assumes that it is through physiotherapeutic activities that progress can be achieved. In some instances, including the next extract, the assurance of progress is relatively explicit, in this extract it is subtler. For instance, the patient implies an expectation of therapy-related progress in his talk of: **y know ↑get some muscles back (again)** (86); and earlier the therapist says **that’s our <biggest problem walking at the moment** (51); ‘at the moment’ implying the temporary nature of the problem. Her proposals for treatment actions, e.g. **I think it’s worth spending the time as- ↑as we ↑have been doing** (59) carry an implication that such activity is ‘worth it’ because progress is possible. Thus, alongside and inherent to this

⁴³. Cognitive and perceptual abilities are frequently impaired in stroke.

assumption of progress is a justification of continued participation and efforts in therapy. In this way, explaining and justifying therapeutic actions to patients is interactionally linked to motivating them. We will see this link time and again in the forthcoming extracts.

The next extract illustrates another common location for talk about rationale: this being just subsequent to positive evaluations of a patient's achievements.

S4Ph9PaST1/10.48

This extract comes from the end of a treatment session. The patient suffered a relatively mild left-sided stroke three weeks before. Using a walking frame, she has just walked the length of the gym with the assistance of Physiotherapist 9 and a junior physiotherapist. She sat down in her wheelchair, and the junior produced a positive evaluation of this 'good sit'. Shortly afterwards the extract begins with Physiotherapist 9 producing positive evaluations of the patient's walking performance, and possibly of her overall performance in the session:

1-17, simplified

- | | | |
|----|---|--|
| 1 | T | you've done ↑ <u>very</u> ↓well
(0.5) |
| | P | good. (I'm) glad to hear that
(.) |
| 5 | T | <u>much</u> better
(1) |
| | P | °can't talk very well° |
| 10 | T | (patient ↑name) (.) we need to (.) make sure that you
can <u>walk</u> on yer own don't we |

(.)
 14 P ooh we do:
 T yeah so that {you can n:}
 P {we ↑do: }
 17 P an I'll (t) try and ↑help

After a series of positive evaluations (prior to this extract, and lines 1 and 5), the therapist changes topic: **we need to (.) make sure that you can walk on yer own don't we** (10). In the context of the patient's recent assisted walk, this utterance contrasts the patient's current abilities with walking 'on yer own'. This seems to counterbalance the prior positive evaluations of achievements. It implies the persistence of some shortfall in physical abilities, and thus the need for continued collaborative therapeutic activity – what we need to do. Parenthetically, the therapist avoids actually specifying this shortfall in ability. This is consistent with findings in the previous chapter that therapists avoid bringing problems of performance to the verbal surface of interactions with patients. Also of note is that an aim of walking without assistance is assumed by the therapist rather than negotiated or elicited from the patient. Noticeably, the patient strongly agrees, at least verbally: **ooh we do:** (14). This perhaps bears out Payton and Nelson's (1996) suggestion that, in some elements at least, the goals of therapy are "obvious and commonly understood" by patients and therapists (p35).

The patient asserts her commitment to efforts and co-operation with the therapists towards improvement: **an I'll (t) try and ↑help** (17), displaying 'good patienthood' in her explicit commitment to efforts in therapy, thus verbalising the keen participation we saw manifest in patients' physical displays in Chapter 4. At the same time we can note that her talk implies

possible lack of competence to help, and establishes a difference between her abilities and the therapist's at the same time as showing co-operation.

17-46, simplified

- 17 P an I'll (t) try and ↑help
P voice sounds tearful towards end of this utterance
- T =↓yeah >you're doin everything ↑right (.)
T so far {t- (.) } to ↑get there
J {↑mm}
- 22 P raises hand towards own mouth
- (.)
25 P hand is now resting on her chin,
looks down and right, away from the therapist
(**Framegrab 6e, overleaf**)
- T brings a hand to patient's shoulder
T ↑alright
(0.5)
T °jus gonna take you back° ((soothing tone))
?P t
(1)
T you're doin everyt↑hin {↑right }
J {you ↑a}re you're doin ever so well
J (patient {name) mo}re than you realise
T {ny- }
- P ↑u↓uh
44 T =an we'll sort you out with the right frame or ↑whatever
T (.) an you'll be fi:ne
45 P good ((sad tone))
46 T ↑alright (.) well done you've done brilliantly

Whilst asserting that she will try, the patient also displays various signs of distress in her voice tone, downcast gaze, and in bringing her hand to cover her chin and mouth (Framegrab 6e). In providing reassurances, both therapists respond to these actions as displaying upset. At the end of the sequence, Physiotherapist 9 produces talk about the therapeutic plan of

action, and a glossed but explicit assurance of progress: **an we'll sort you out with the right frame or ↑whatever (.) an you'll be fi:ne** (44).



Framegrab 6e

Apparent in this extract is one of the interactional difficulties which can result from formulating reasons and rationale based on shortcomings of performance: soon after the therapist alludes to what has not yet been achieved, the patient shows distress in her body movement and voice tone (22, 25, and Framegrab 6e).

As in the previous extract, a link between motivation and rationale is apparent. The positive evaluations at the start imply achievement, but almost as if these positive evaluations might undermine continued efforts in therapy,

the therapist topicalises what still 'needs' to be achieved. Thus she seems to orient to a need to make the case and build motivation for continued therapeutic participation and effort.

The next extract provides further evidence of a link between motivation and rationale. In it, the therapist topicalises the purpose of what is being done in the face of conduct by the patient that implies a lack of motivation.

S1Ph2PaCT2/2.59

(Volume 2, pages 73-75)

The patient has been in therapy for over three months. The therapist described him to the researcher as particularly difficult, and said she believed he could walk if he really tried. A number of therapeutic and interactional difficulties are apparent throughout the recordings of his treatments. In particular, he recurrently does not respond, or responds with opposition or resistance to the therapist's utterances⁴⁴. For example, just before this sequence starts the therapist has asked the patient how his leg feels. He looks away and does not answer. Then during lines 1-22 the therapist four times instructs the patient with regard to keeping his knee straight, but it appears from the video that it is the therapist rather than the patient who straightens this knee. During the knee straightening exercise, the therapist

⁴⁴. Seen in extract S1Ph2PaCT4/11.54, Chapter 5.

remarks **ooaa (.) don't know about you (patient name) but I'm gettin very hot here** (10). This implies expenditure of effort on her part, and is hearable as expressing uncertainty as to the patient's degree of effort. Talk about the purpose of the activity arises soon afterwards, i.e. it is sequentially proximate to therapeutic and interactional troubles. The therapeutic troubles concern the failure to straighten the knee, and the interactional troubles include the lack of displays of effort on the part of the patient, and his failure throughout the extract to return the therapist's gaze. As the following lines start, knee straightening efforts have ceased, and the therapist has instructed the patient to sit down. The therapist remains kneeling on the floor at the patient's left side. As the patient sits still, silent, and gazing forwards (Framegrab 6f), the therapist topicalises the purpose of doing the activity (41).



Framegrab 6f

25-66, simplified

- 25 (4)
P *sits down smoothly and slowly*
- T *glances at patient then at door of treatment room*
T *good (.) that was better*
P *looks straight ahead*
- (2)
- T *glances at patient*
T O↑K
P O↓K
- (3)
- T *looks at patient and moves head so that her face is more aligned towards him*
- 41 T *can you see the purpose of this (.) doing this*
42 P *yes*
P *leans back slightly*
continues gazing ahead
- T *drums fingers on treatment bed for first few seconds, looks at patient through most of the silence*
(23)
P *looks ahead*
- 49 T *right*
- T *turns and tilts head more to the patient and leans towards him slightly*
(0.5)
- 54 T *so going again*
(1)
P *no movement*
- T *taps patient's left hip, continues to look at him*
- 59 T (n) try and get it so you can do it (0.5) with minimal ass↑istance
T (with) keeping this foot down
(2)
- 63 T OK (.) that's the aim of today
(2)
- 66 P *starts to lean forwards at end of this pause*

When the therapist asks the patient if he can **see the purpose** of this, he responds minimally: **yes** (42). A relevant response would have been for him

to indicate his understanding of the purpose but he does not do so, even during the persisting silence afterwards, which leaves the topic open and relevant, and his lack of an answer accountable. Throughout the 23 second silence, the patient does not look at the therapist despite her maintained gaze to his face (Framegrab 6f, above). Movement of his gaze to the therapist would be expectable in these circumstances (Goodwin, 1979) and failure to do so may carry the implication that the patient is 'actively' disattending her (Heath, 1986). Finally the therapist breaks the silence with **right** (49), then **so going again** (54). This makes a physical response (standing up) by the patient relevant. However, he shows no sign of doing so, and the therapist expands on the instruction and formulates it as the aim for today (59, 63), i.e. she re-topicalises rationale of the activity, though not the purpose *per se*. Following this, the patient begins to attempt to stand.

Thus, this therapist topicalises 'purpose' in the face of several interactional and therapeutic troubles. Because of its sequential location, she implies through her talk that his apparent lack of responses and efforts may relate to a failure to understand the purpose of the activity. That is, understanding purpose seems oriented to by the therapist as something that encourages a patient's motivation and response.

In the extracts so far, it is the therapist who introduces the topic of rationale, purpose or aims of activities. There are only two or three instances in the data collection where a patient apparently introduces such issues. The following extract is one of these and is unusual in this respect. However it

shares features in common with other extracts in that the topic arises in circumstances of therapeutic and interactional troubles.

S3Ph5PaNT2/2.25

(Volume 2, pages 76-87)

This extract comes towards the end of a treatment. The patient's stroke occurred five days beforehand and this is only her second treatment in the gym. The stroke has affected her right side. She also has some dysphasia and dysarthria which means she has difficulties finding words and articulating them. Physiotherapist 5 and an assistant are helping the patient maintain a standing position whilst she practises various movements that challenge her balance. In particular, the patient is being encouraged to reach towards the assistant's outstretched hand with her left, i.e. her unaffected hand. As she reaches up and down, the assistant and therapist guide the patient in transferring her weight from side to side (Framegrab 6g, overleaf).



Framegrab 6g

A series of troubles are evident at the beginning of the extract. At one point the therapist indicates a problem; in doing so, she addresses her talk to the assistant, however, the patient appears to treat this as a trouble and produces an apology.

27-33, simplified

27	T	°OK h think we just lost° the h{ips }
	A	{yeah}
	T	that time {(assistant name) so}
33	P	{I'm sor↑ry }

After further repetitions of the activity, the patient indicates other troubles:

55-71, simplified

- 55 T =well done (patient name)
56 P mouths 'well', glances to therapist, then looks to assistant
- P I I (haven't go{t the})
A { so}
60 P shaking head and looking towards assistant
- A ↑hips fir{st}
P {I:}:
P turns head the opposite way to look to therapist
- T looks to patient's face
P haven't got the hang of this
- T at patient's face
71 T yeah I think you perhaps ↑have

Thus, after several non-verbal actions which imply disagreement with the therapist's positive assessment: mouthing 'well', shaking her head and furrowing her brow (56, 60 and Framegrab 6g, above), the patient verbalises a negative evaluation of her ability – that she hasn't got the hang of it. The therapist disagrees (a common response to a patient's negative evaluation – see previous chapter). The activity recommences, but a short time later the patient indicates further problems. First she seems to ask for the activity to be paused: **just a minute \$a↑right heh\$** (123 – Volume 2). After a pause, the exercise is recommenced, the therapist instructs her to tap the assistant's fingers, and the patient indicates further problems (line 201 onwards):

193-242, simplified

- 193 T ↑five taps for {me}
P {oh } you want me to go{(t:)}
T {l } certainly do=
T =five ta{ps (ic)}
197 P {ooh l }
T go on = like that ↑one. two.
A =yer hips over
(0.5)
T and then come back (.) cross
(.)
203 P but um hhhhhhhhhhh tch °hhhhhhhhhh
(1)
205 P (it is the bit (.) affect the that side) it didn't affect ↑that side at all
P *looking at therapist, ((face expression looks puzzled))*
indicates her left hip with her left hand,
head gestures towards left side
(.)
T the ↑stroke ↓hasn't
P n.
T is that what you ↑mean the stroke hasn't affected ↑that side
P ↑no
(.)
P um
T do you want to sit down and tell ↑me or
(.)
P no I'll be alright in a minute
218 T are you thinking that we're working that arm getting
T you to ↑do things (.)
219 T {and that isn't} the ↑weaker arm is that what you're saying
P {°h ()}
221 P =I'm trying to figure out °hh what (the right) to ↑do
T yeah (.) OK
P (I'm) alrigh
224 T =is that what you mean {(.) th}at you think that the
P {uh }
T stroke hasn't affected
226 T that arm and we're asking you to ↑do things with that arm
P ↑no
T =no OK
229 P but um
(1)
231 P aah (.) I'm getting so \$bamboozled with which leg's which\$
T °↑O↓K°
T {tell me what you're}
A {finding it diffi↑cult }
T bamboozled {with}
P {↑no}

P I'm (all) bamboozled °hh
 P ↑with ↓what I'm supposed to ↑do
 T OK (.) well we're practising standing (.) OK}
 P {yes }
 242 T and we're just trying to practise getting you to take
 weight through both legs...
 ((explanation continues over several turns))

At the start of this sequence, the therapist instructs the patient to tap the assistant's fingers. Although the patient attempts this, her verbal response **ooh I** (197) implies some concern or doubt and her facial expression echoes this. Her concerns are elaborated in subsequent turns: **but um**

hhhhhhhhhh tch °hhhhhhhhh (it is the bit (.) affect the that side) it didn't affect ↑that side at all (203-205). The therapist indicates she has not fully understood and seeks clarification (208-210) to which the patient responds no. The therapist nevertheless goes on to offer a candidate version: **are you thinking that we're working that arm getting you to ↑do things (.) and that isn't the ↑weaker arm is that what you're saying** (218-219). In response, the patient produces a somewhat different problem: **I'm trying to figure out °hh what (the right) to ↑do** (221). Noticeably, this version of the problem centres on the patient, and her efforts to 'figure out' what to do; whereas her earlier utterance appeared to be more of a question about why the current activity was being performed, and is treated as such by the therapist. Although the patient has produced a different problem, the therapist reproduces her candidate understanding of the earlier version: **is that what you mean (.) that you think that the stroke hasn't affected that arm and we're asking you to ↑do things with that arm** (224-226). This time the patient replies 'no', then produces a further version of the problem,

starting: **but um aah (.) I'm getting so \$bamboozled with which leg's which\$** (229-231). Again this is personalised – it concerns *her* difficulties rather than the therapy itself. Nevertheless, the therapist provides an explanation that responds to the sorts of concern implied in the patient's earlier utterances and the therapist's candidate versions. The therapist's explanation is extended over several turns and attends specifically to explaining why the treatment is focusing on the unaffected side:

what we're trying to do by getting you to reach over and move yer weight onto ↑that: ↓leg °h O↑K = is trying to retrain some balance so that you can move yer weight from ↑one leg to the other..... (257-264, see Volume 2).

Summarising this extract, talk about why an activity is being performed again arises in the face of *problems of performance* including the therapist's problem evaluation concerning 'losing the hips' and the patient's expression of concerns about her grasp of the activity. *Interactional problems of understanding* are also apparent. The sequence is unusual in that the patient rather than the therapist initiates the topic of rationale. She does this tentatively and rather ambiguously and subsequently denies having done so. Examination of the sequence is complicated by the patient's speech impairment, which makes it hard to decipher precisely the words used. This is not a major handicap to analysis however, because analytic claims are based in what participants visibly and hearably orient to. In the extract, the therapist hearably orients to what the patient says as questioning why an

activity is being done. We see this in the candidate understandings she produces, and in her subsequent explanatory talk.

In previous chapters we observed that patients tend to avoid performing actions which have the potential to imply that the therapist's authority and expertise is being questioned. It seems likely that the infrequency and tentativeness with which patients ask therapists for explanations reflects this same orientation. We discuss explanations for this aspect of patients' conduct further below (Section 6.9).

6.4.1 Reasons proposed as underlying therapy and therapeutic activities

Above, we have seen that various rationales underlying therapy are brought into being through talk in the course of therapist patient interactions. These include basic functional reasons – allowing something to happen such as moving a table (S2Ph5PaMT1/2.13); more technical therapy-based reasons – getting weight through the affected leg (S3Ph5PaNT2/2.25); and impairment-based reasons – revolving around various shortcomings in current physical abilities compared to previous or 'needed' abilities (S4Ph9PaST1/10.47). At another level, the talk portrays more independent, 'proper', 'normal' physical activity as an appropriate and shared aim of therapy (S2Ph5PaMT1/2.13, S4Ph9PaST1/10.47). All these reasons are based upon, and indeed interactionally construct, a logic that progress is possible and is contingent upon participation in the proposed therapeutic activities. Treatment goals are another element of rationale that is 'talked

into being' and will be examined after a summary and exploration of the findings of this chapter thus far.

6.4.2 Summary: location, structure, content and interactional functions of communication about reasons and purposes

The foregoing analytic chapters showed that throughout physiotherapy, patients and therapists communicate about how treatment activities are to be performed, and what counts as successful or problematic achievement. Data extracts illustrated that developing mutual understanding about these matters is a requirement for successful accomplishment of physiotherapy activities. Also that when problems of understanding arise, both therapists and patients orient to their recognition and repair. In contrast, communication about 'why' activities are performed arises less frequently in the data, and if there is lack of understanding, this rarely comes to the interactional surface.

Talk about reasons and rationale is often located towards session starts or ends, with therapists giving reasons for what they are proposing for the forthcoming or subsequent session. Occasionally reasons are verbalised within instruction turns and when standardised clinical assessments are introduced. The topic also arises in association with evaluations of performance. When evaluation concerns a problem, that problem itself is formulated as the reason for a forthcoming activity. After evaluations of success, areas of less success are sometimes topicalised as reasons for continued therapeutic efforts. Reasons are also talked about in circumstances of difficulties. These entail interactional troubles – such as

distress or lack of understanding, and troubles of performance – such as failure to achieve instructed treatment activities, and/or to show efforts to do so.

A study of doctor's explanatory talk (Peräkylä, 1998) sheds some light on why physiotherapists sometimes verbalise reasons, but at other times do not. This research analysed primary care doctors' diagnostic statements, and particularly the presence or absence of any reference to evidence underlying their diagnoses. Most frequently, doctors gave their diagnosis without referring to how it was reached. Peräkylä calls these statements 'plain assertions'. However, at other times, doctors incorporated some reference to the evidence underlying their diagnosis. Likewise, therapists frequently do not refer to reasons underlying their instructions or proposals, but sometimes they do. Peräkylä's examination of the circumstances wherein doctors do and do not refer to evidence is informative. He found that plain assertions most often occurred where there was "an observable and inferable link between the examination, which the patient participates in or witnesses, and the doctor's diagnostic statement" so that the "activity context provides for the observability and the intelligibility of the evidence" (p307). Similarly, in physiotherapy, the intelligibility of current actions is often provided for by the context, for instance a prior physical examination or report of a problem (*c.f.* S2Ph2PaHT3/11.44).

Peräkylä found that one circumstance in which doctors explained their diagnosis was when the diagnostic turn was detached in some way from the

diagnostic examination. Again, there are parallels with the physiotherapy data. When therapists outline the proposed content of a session, this may come before any attention to specific body parts or movements, or may concern different foci to those most recently attended to. That is, when a therapist proposes a plan for the day's session, reasons for it may not be directly inferable or intelligible purely from the local context and the therapist may therefore explicitly address these through talk.

The other circumstance in which doctors in Peräkylä's data referred explicitly to evidence was when some sort of uncertainty and/or disagreement about the diagnosis arose. He argued that on these occasions, the doctor's authority as an expert is potentially undermined, and that this leads to interactional work in which doctors account for and assert this authority. Similarly, in the physiotherapy data, we see therapists explaining proposed treatment activities in situations where there is potential for a patient's disagreement or distress. This was apparent in S2Ph5PaMT1/2.13 wherein the therapist proposed restricting walking, also in S3Ph5PaNT2/2.25 where the patient seemed to question an exercise that involved her non-affected side. So, where there is potential disagreement or questioning of an activity, therapists, like Peräkylä's doctors, may orient to providing an account for why they are proposing or performing the particular treatment. (See further discussion in Section 6.7).

Extracts illustrated that it is nearly always therapists who instigate the topic and who have most of the longer turns on it. In their responses, patients

generally agree and acknowledge. Occasionally, patients produce longer turns which display their own understandings of the reasons and purposes of therapy. Very infrequently, patients initiate the topic of rationale. However, unlike therapists, they do so tentatively and ambiguously.

In terms of interactional functions and effects of the patterns of conduct we have described, one basic distinction arises between episodes where reasons are verbalised, and episodes where they are not. When reasons are verbalised, both interactional participants and analyst can make inferences about the degree of mutual understanding. Verbalisation can also provide opportunities for patients to display their own competence and knowledge. It can allow topicalisation, usually rather subtly, of the 'deeper' rationale underlying physiotherapy. When reasons are not verbalised, they may be intelligible because of the sequential location of the actions; however, in these circumstances there is less opportunity to evaluate a patient's understanding.

We have noted that indicating patients' physical problems can serve as a resource for justifying therapeutic activities, and grounds for encouraging participation and efforts in therapy. However, raising problems in the course of explanatory talk has disadvantages in that it may provoke displays of negative affect such as distress.

Telling patients why activities are requested and performed can also function as a persuasive strategy: justifying and encouraging expression of

compliance. We saw evidence for this in that reasons and rationale are often topicalised when problems of patients' performance or efforts are apparent. These are occasions when persuasion and motivation may be needed. Evidence for the effectiveness of this strategy was seen in patients' expressions of agreement with therapists' statements and proposed actions. An expectation of progress, contingent on participation and efforts in the proposed treatment activities runs through talk about reasons for treatment activities. This forms part of the persuasive, motivational element of interaction on this topic.

The data suggest that where patients raise the topic, one potential effect is to imply questioning of the therapist's authority and expertise. We see evidence for this in the way patients treat 'asking why' as interactionally delicate. In previous chapters, we observed that patients avoided, or treated as delicate, actions which might imply questioning of the therapist's authority (for instance questioning therapists' instructions). Arguably, asking *why* activities are being done may be even more 'delicate' because it implies questioning not only their actions but also the reasoning behind them. This would seem likely to be an important factor in explaining why patients rarely do it. Even where issues of professional authority are not involved, people rarely ask one another to explain the reasons underlying their actions, doing so seems dispreferred (Garfinkel, 1967). This is likely to further explain why patients do not 'ask why'. However, this is to pre-empt issues which we will discuss at greater length once we have examined goal-setting.

6.5 *Data analysis: interaction about goals*

We now examine three interactions concerning treatment goals. Two of these entail goal-setting. As stated earlier, such episodes are infrequent, but are of analytic interest because published policy and recommendations strongly encourage goal-setting. Different degrees of patient contribution to the process are illustrated in the extracts. In the second extract, the patient's contribution to producing the topic on which the goal is set, and in negotiating the precise goal is greater than in the first. This greater involvement seems to present various interactional problems.

S1Ph1PaBT2/11.04

(Volume 2, pages 88-91)

This patient had been receiving rehabilitation therapy since her stroke seven weeks before. At the time of recording, she needed help of one person to 'transfer', i.e. to get to and from a chair to the bed, toilet etc. She was not walking outside therapy, though she was able to take a few steps with the assistance of one physiotherapist. The therapist in this extract was recorded performing goal-setting more often than any other therapist⁴⁵.

This episode comes close to the start of the treatment. The therapist has assisted the patient onto the bed, and wheeled the empty wheelchair away.

⁴⁵. However, inferences we can make from this are limited, partly because this therapist was recorded treating three different patients whereas some therapists at Site 3 who topicalised goals during recordings were only recorded with one patient each.

The lines reproduced below start as the therapist re-enters the treatment cubicle.

6-38, simplified

- 6 T °h right <so then just thinkin about um
(2.0)
- 13 T things that we need to work on you've got your
hh°hh transfers now do{ne with} yer family
- 14 P {yeah }
- 18 T so that's ↓good but ultimately I'm sure you'd like to be able to
transfer on yer own wouldn't you
- 20 P yeah
- 24 T so: °hhh we could still do I'd (.) st- >you're very near
to standing independently {↑aren't ↓you } but probably you
- 25 P {yeah mmhm }
- T wouldn't trust yourself to do it quite {on yer own }
- 30 P {not just just} yet >no
- 34 T >so maybe we could have that as a ↓go{al }
- P {mm}
- 38 P =↑mm

The therapist's introduction of **things that we need to work on** forms the start of a goal-setting sequence. Opportunities for expression of the patient's views are limited. On the other hand, she produces fairly strong agreement with the therapist's statements, nodding throughout much of the therapist's talk and saying **yeah** not only at turn transition points (e.g. 20), but also in overlap with the therapist's talk (14, 25). She produces comments that show alignment with and some elaboration upon what the therapist says (30, and 49 below). Also contributing to the collaborative 'style' of the talk is the therapist's use of the word 'we' (13, 34). Actual elicitation of the patient's views within the extract is minimal. However, it is not accurate to say that this therapist's actions do not incorporate the patient's views at all: four minutes earlier, the following exchange was recorded.

S1Ph1PaBT2/11.00

*Participants are off camera
the therapist is helping the patient to stand up from
a seated position on the toilet*

- T °nice n ↑tall°
(1.5)
P me son was quite impressed that I could man(age)
T was e?
P ye{ah }
T { mm:} good
(0.5)
T now then d'you want to reach onto your: with your good ↑arm
T and help me with (.) >the other side of your underwear: (.) ↑yeah

The patient's report of her son being impressed appears to refer to her ability to transfer with help. Thus the topic was not taken up by the therapist at that time, but she returns to it within the subsequent goal-setting sequence.

In this goal-setting sequence, the therapist proposes a rationale for the goal which has been encountered several times in previous extracts: she assumes that independence in physical tasks is an appropriate and shared aim: **ultimately I'm sure you'd like to be able to transfer on yer own wouldn't you** (18). Other elements in this sequence which are common to other extracts we have examined in this chapter include: topicalisation of areas that remain unachieved following a positive evaluation (18), and an assumption that progress is possible. This is seen in the therapist's talk: **you're very near to standing independently ↑aren't ↓you** (24) and that of the patient (30):

- 29 T =but probably you wouldn't
T trust yourself to do it quite {on yer own }
30 P {not just just} yet >no

The therapist goes on to propose a time within which the goal is to be achieved and respecifies the goal somewhat:

34-72, *simplified*

- 34 T >so maybe we could have that as a ↓goal }
P {mm}
- 38 P = ↑mm
T = t do it (.) ↑say in a ↑week
P ↑yes
P *lots of nods*
- 46 T =to be able to stand in physio without me doing a ↓thing
P *nods throughout*
- 49 P that'll be ↓good
T yeah in > fact I ↑think you could almost do it now >that's the thing maybe you ought to not do it in physio maybe you ought to be able to do it on the ward as well
T {°hh }
P {mmhm}
T so from yer ↑wheel↓chair {to } be able to sta:nd on yer {own }
P {yeah} {yeah}
P *repeated nods*
- T *thumbs up sign, then touches patient's left hand*
T >brilliant OK °well we'll have that ongoing°
°hh well this is feeling quite O↑K
(*referring to the patient's affected hand*)
- 72 P ↑yeah

In this part of the sequence, the therapist attends to setting the goal at an appropriate level of challenge. She initially suggests being able to stand from the treatment bed **without me doing a ↓thing** (46). She then revises this to being able to stand from a wheelchair on the ward without physical assistance.

In summary, very different levels of contribution by patient and therapist are evident. It is the therapist who initiates a goal-setting sequence, proposes

the physical activity for which to set a goal, proposes the time limit for it, and brings the topic to an end. Although the activity for which the goal is set was earlier made relevant by the patient, her expressions within the sequence are limited to agreements. That is, though goal-setting is interactionally presented by the therapist as collaborative, substantively it is not.

The next extract, which involves the same therapist with a different patient, illustrates a different distribution of interactional actions.

S1Ph1PaGT1/11.11

(Volume 2, pages 92-108)

This session involves a patient who had a relatively mild stroke five days before. He received rehabilitation on the same ward several months ago following a previous stroke. This is the patient's first treatment in the gym after his readmission. Like the previous extract, this sequence comes from the start of a session. The patient and therapist have walked into the treatment cubicle, the patient sits down on the treatment bed. The therapist sits down on a wheeled stool, positioning it to directly face the patient (Framegrab 6h). The sequence begins with a lengthy therapist turn announcing what she wants to do in the session and why (2-15).



Framegrab 6h

2-78, simplified

- 2 T °↑O↓K: = well whad I want to do today is just have
T a: good look at (.) (h) how
T yer trunk is and how yer arm is really and how yer able
T to ge(t) up n off the bed n things like that really
T just to get a good ↑picture of what you:'re able to do so that
T we can work out whe:re there's problems
15 T and what we can ↑do about them is that O↑K
(1.5)
23 T what would ↑you say your biggest problems are
(2)
31 T whilst you're here in ↑hospi↓tal
(2)
P my ↑left and ↑right arm
T =your left ↑and right ↓arm

(2)

P when I fell I (h)it both the elbows here

T =ri{ght }

P {(they're)} (very) painful

T so the ↑pain in your left and right arm >is your biggest <problem (0.5)

P yeah

T OK: °hh do ↑you =is there anything

T that you ↑can't do at the ↑mome:nt (.)

T um that you'd ↑like to be able to do by the time

T that you go out of hospital

75 P put me socks on

78 T put yer socks on OK so what ↑limits you puttin yer socks on

After announcing her intentions for the session, the therapist asks the patient for his view of his problems (23). In the sequence that follows, two problems are talked about: pain in his arms and difficulties putting his socks on. The latter problem is taken up as an extended topic, elaborated through questions and responses and physical demonstration. It is eventually formulated as a goal by the therapist (see below).

Of particular interest are those interactional actions by which the therapist shapes and selects the problems the patient topicalises. The format of her first question: **what would ↑you say your biggest problems are**, allows a wide range of possible responses. A two second pause follows, with the patient producing no verbal response, and moving his gaze downwards, away from the therapist's face (28 - Volume 2). The therapist then specifies the question somewhat and after a further two second pause the patient produces a response: **my ↑left and ↑right arm** (37). The therapist's response indicates some surprise: **= your left ↑and right ↓arm**. The higher pitched ↑**and**, and the emphasis on left indicating his response is being

questioned⁴⁶. In response, the patient produces an account for and elaboration of his statement. Following this, the therapist acknowledges but does not pursue the stated pain problem. Instead, she changes topic, closing down the current one with an 'OK' (*c.f.* Beach, 1995) then soliciting further problems: **do ↑you =is there anything that you ↑can't do at the ↑mome:nt** (64, 67), and after a short pause: **um that you'd ↑like to be able to do by the time that you go out of hospital** (71). The patient responds **put me socks on** and the therapist takes up this problem with a sequence of questions that investigate the problem. For brevity, we will not examine this sequence (78-167 - Volume 2). We return to the session a minute or so later. The patient has been asked to demonstrate the difficulties of putting on his socks by reaching down towards his feet. He is doing so as the following lines begin:

167–187, simplified

- 167 T >and back up again °hh so. (.)
P *starts to come up*
- T we could ↑probably: (e) set a ↑goal then
T for you like a ↑gi- like a ↑joint goal that
T we'll- I'll (.) look at at achieving with the occu↑pational therapists
180 T °hh that you can ↑reach and put yer ↑socks on °h
↑maybe we should say
184 T within (.) ↑two weeks that you can do ↑that
d'you think that's fair en↑ough
187 P =↓ (.) I ↑put them on ↑now by >laying on the bed

⁴⁶. The therapist's surprised or questioning response seems associated with an expectation that a stroke patient's arm problems will involve one side (the affected side) of the body.

The therapist's instruction to the patient to rise is closely followed by a proposed goal: **>and back up again °hh so. (.) we could ↑probably: (e) set a ↑goal then** (167, 171). 'So' often forecasts production of some form of summarising talk (Heritage and Watson, 1979) and also a forward movement on a topic (Jones and Beach, 1995). Hence 'so.' here ties the goal to the topics and actions that have just occurred. The goal is thus portrayed as related to and as a progression of the examination of his physical limitations. Her proposal is somewhat tentative and she seems to express equivocation about just who it is who is involved in achieving the goal:

we could ↑probably: (e) set a ↑goal then for you like a ↑gi- like a ↑joint goal that we'll- I'll (.) look at at achieving with the occu↑pational therapists.

The initial 'we' seems to portray collaboration between patient and therapist. However, as she talks about achieving the goal she repairs from 'we' to 'I', and also mentions 'the occupational therapists'. The therapist's tentative and disrupted talk may reflect local interactional circumstances, particularly the lack of spoken or nodding acknowledgements from the patient: he gazes at the therapist, but sits still (some disagreement is indeed on its way, see line 187). On the other hand, the therapist's equivocation may reflect broader ambiguities about who goals are for: whose role it is to carry them out and achieve them. The eventual statement of the goal itself is more straightforward and less disrupted: **that you can ↑reach and put yer ↑socks on** (180).

Having stated the target, the therapist proposes a time limit for its achievement, then pursues a response from the patient: **maybe we should say within (.) ↑two weeks that you can do ↑that d'you think that's fair en↑ough** (180,184). However, the agreement she projects is not forthcoming, instead the patient produces a statement that indicates that he can in fact put his socks on: **=↓ (.) I ↑put them on ↑now by >laying on the bed**. This contrasts with the strong agreements with which the patient in the previous extract met the therapist's formulations of the problem and the goal.

This statement by the patient potentially derails and undermines the basis on which the therapist has set the goal. However, in the following sequence she manages to (re)build its justification by pursuing and eventually attaining agreement from the patient that his current method of performing the action differs from what he would normally do at home. This resembles a practice identified by Sacks (1987), whereby compromise is reached through a series of turns ostensibly addressed to 'better understanding', and allows her to restate the goal with a slight modification.

187-263, simplified

- 187 P =↓ (.) I ↑put them on ↑now by >laying on the bed
T ↓ri:ght so you've ↑found one method >of doing it
T but would you ↓nor:mally
T when you're at ↓home do it in ↑sitting
(0.5)
P normally
208 T =right so we'll ↑try an look at ways of doing it in ↑sitting (.) within
211 T a a fortnight ↑yeah >so you can do
P drops chin down once
215 T it <com↑pletely on yer own °hh

Lines omitted in which therapist describes physical techniques by which patient might achieve the goal

- 235 P =(I) usually ↑lie down n
P n m: ()
T n do it >↑at the ↑mo{↓ment }
P {°()°}
T <↑O↓K. so °h we'll look at ↑one then for putting yer socks on
251 T is there anything with yer ↑arms that you've got problems with
255 T you know ↑actually using yer arms is
T there ↑any ↑activity that you've found you ↑can't ↑do
259 P =↑writing
263 T °h writing (.) alright ↑now (are) you ↑right or ↑left handed

So, the patient reiterates his current ability in regard to putting on his socks (235). The therapist handles this by noting that this is 'at the moment', then restates the goal: **so °h we'll look at ↑one then for putting yer socks on.** She then changes topic through a further question about the patient's problems (251,255). The way she formulates this question strongly constrains relevant problems. Referring to 'actually using yer arms' makes problems relating to use of his arms relevant but his earlier stated pain problem irrelevant. This strategy proves successful in that the patient produces a new problem that the therapist takes up and for which a goal is subsequently formulated. However, like the 'socks' goal, achieving mutual understanding about the precise nature and scope of the patient's stated problem proves difficult, and his agreement with the proposed goal is neither immediate nor fulsome.

292–352, *simplified*

- 292 T °h right so you ↑can't write so we could look at how you
T ma- (how you're) able to ↑write as well
P >I used to be able to <write ↑nicely

T ↑OK: can ↑you: at the ↑moment write yer signature or ↓not
 (.)
 306 P ↑just.
 T right so we could im↑prove >maybe on yer ↑signature
 (1.5)
 P >I have to se- <sign me (.) h me: (.) ↑pension ↑book
 T yep
 (0.5)
 P n me cheques
 T ↑O↓K >well <shall we try an ach↑ieve that in a ↑week to
 T have a more (.) legible: signature
 (.)
 T d'{you ↑think}
 332 P {oh it's } ↑legible
 T ↑right but you you would prefer it to be better than it is
 P yes
 T O↓K so (.) °hhh so for you to be happy with yer signature
 maybe in a week ↑yeah
 (.)
 P yeah
 T ↑O↓K right then would you ↑mind (.)
 T (patient name) >is it alright if I call you (patient nickname)
 T not <(more formal name)
 352 P I should ↑like you ↓to

Remembering that at line 259, the patient answered **=↑writing** in response to the therapist's solicit of **any ↑activity that you've found you ↑can't ↑do**, it now transpires that the patient's view of his problem is that he *can* write his signature, though 'just' (306). The therapist's subsequent proposed goal assumes a problem of legibility, to which the patient produces a counter-statement: **oh it's ↑legible** (332). The therapist manages to 'rescue' this goal as she did the 'socks' goal, but with a different strategy. She unilaterally reformulates it so that the goal is for the patient to 'be happy with' his signature. After a fairly short pause, the patient's verbal agreement is forthcoming: **yeah**, though rather muted in tone and with his gaze downwards and no accompanying nods (341 – Volume 2).

Summarising this extract, the interactional activity of goal-setting was again introduced by the therapist. However, in this extract, goals were based upon problems directly elicited from the patient during the sequence. The therapist solicited these in a way that (increasingly) constrained the sort of problem the patient introduced. This functioned to elicit problems that the therapist treated as relevant for formulating into goals. Once a problem had been topicalised and a goal proposed, difficulties arose. The patient twice provided a further statement about the nature of the problem which potentially invalidated the goal. In the first case, the therapist managed this by establishing with the patient that some form of shortcoming in his abilities did exist, and then reformulated the goal by adding detail to it. In the second case, the therapist changed the goal to fit with the patient's portrayal of the problem.

The extract illustrates various challenges and problems that can arise when a therapist seeks and attempts to incorporate a patient's views and preferences into goal-setting. Seeking patients' views is difficult for at least two reasons: first, a patient may be reluctant to state problems, second, a patient is likely to perceive many problems in many different areas. Ensuring that physiotherapy-relevant problems are elicited is thus facilitated by the therapist constraining patients' responses. We saw this in the foregoing extract when the therapist asked questions that projected and constrained particular responses. In several other goal-setting episodes, including the earlier extract (S1Ph2PaBT2/11.04), these difficulties are avoided because the therapist identifies and introduces the problem herself.

The two second pauses that follow the therapist's early questions during this extract, and his gestures (20, 24) provide some evidence of reluctance on the part of the patient to respond to the therapist's elicitation of problems. We cannot assert whether this is a recurrent difficulty during goal-setting because there are too few goal-setting sequences in which patients' views on their problems are sought. However, this does seem possible in the light of earlier findings that patients can be reluctant to comment upon their own abilities (Chapter 5, Section 5.7). We now temporarily turn from this extract to another which provides further evidence of difficulties in attaining any statement of a problem from a patient, and in soliciting 'relevant' and appropriate problems.

This extract does not concern goal-setting *per se*, however, as in the sequence we have been examining, the therapist tries to elicit a problem on which to work in therapy.

S1Ph2PaFT2/1.38

1	T	(patient name) ↑what shall we <u>work</u> on today
2		(.)
3	P	°you're in charge°
4		(.)
5	T	°so↑rry°
6	P	you're in cha:{rge}
7	T	{↑I'}m in char{ge is} there
8	P	{yeah}
9	T	any↑thing specifcily
10		(2)
11	P	°(m:) this ↑finger°
		(Framegrab 6i, overleaf)
12		(0.5)

13 T that ↑fin↓ger
 14 P =↑mm:
 15 (1.5)
 16 T ↓right
 17 (1.5)
 18 T ↑in what res↓pect
 19 (1.5)
 20 P it's ↑not doin nowt
 21 T °right° (.) ↑OK. it's ↑diffi↑cult to get yer finger to straighten
 22 T isn't it (patient name): because of: (.) the con↑tracture in it (.)
 23 T so I don't think we('ll) gunna be able to cha:nge (.) change that
 24 (1)
 25 T cause the ↑muscle's already ↑sho:rtened
 26 (2)
 27 T °↑yeah°
 28 (.)
 29 P °() ↑knackered ↑is ↑it°
 30 T ↓so↑rry
 31 (.)
 32 P scuse me for saying it it's ↑knackered is ↑it
 33 (1)
 34 T °h well yu- (.3) I ↑think what you ↑need to try and do is use the ...
 ((talk on the topic continues for several minutes))



Framegrab 6i

This patient is evidently reluctant to respond to the therapist's solicitation and explicitly states his orientation to the therapist's authority as an account for his reluctance: **you're in charge**. However, the therapist pursues a response, and is successful in that the patient topicalises **this ↑finger** (Framegrab 6i). However, this poses further difficulties. The finger is stiffened because of a Dupuytren's contracture. This predates the stroke and is not remediable through physiotherapy. The therapist says: **I don't think we('ll) gunna be able to cha:nge (.) change that** (23). In doing so she attends and responds to the problem the patient has topicalised, however this entails giving the 'bad news' that this problem is not solvable. As ever, giving bad news risks provoking displays of distress from the patient, and indeed in his subsequent turns his voice tone and facial expression convey disappointment. The therapist's next turns also suggest some form of reparative work for the lack of hope she conveyed: she produces relatively lengthy talk on activities that might stop the finger getting worse. Noticeably she describes these in terms of what the patient rather than 'we' could do e.g. line 34.

In summary, the therapist elicits a problem from the patient that she evidently treats as unsuitable for tackling within the therapy session. Once the problem has surfaced, considerable interactional time and effort is expended by the therapist in accounting for why it is not treatment-relevant, and in avoiding outright dismissal of a treatment preference expressed by the patient.

We now return to the ‘socks and writing’ goal-setting extract (S1Ph1PaGT1/11.11). We have explored problems encountered in *soliciting* problems on which goals are to be based. We now turn to problems that arise regarding *incorporating* these into goals. Differences in perspective appear to contribute to difficulties in establishing understanding and agreement about the problem on which the goal is set. For instance, it becomes evident that therapist and patient are using the word ‘can’t’ in different ways. The therapist seems to refer to a complete inability to do something. Whereas, as the sequence unfolds, the patient seems to be referring to deterioration in his abilities – he can’t write and put on his socks in the way he could before his stroke. Further subtle but fundamental difficulties for reaching understanding and agreement are also apparent. In particular, the therapist’s and patient’s actions seem to be shaped by differing orientations, particularly with respect to acknowledging shortcomings in physical competence. This is a significant problem because identifying such shortcomings necessarily underpins setting of a goal. These different orientations are evident when the therapist’s initial proposals for each goal are met with disagreement from the patient on the basis that the activity is in fact one that he *can* perform. In this, he seems concerned to display competence rather than incompetence.

S1Ph1PaGT1/11.11

171-187, *simplified*

171 T we could ↑probably: (e) set a ↑goal then

Talk and body movement lines 172-179 omitted

180 T °hh that you can ↑reach and put yer ↑socks on °h
↑maybe we should say within (.) ↑two weeks

T that you can do ↑that d'you think that's fair en↑ough

187 P =I (.) I ↑put them on ↑now by >laying on the bed

326-332, *simplified*

326 T ↑O↓K >well <shall we try an ach↑ieve that in a ↑week
to have a more (.) legible: signature

T d'{you ↑think}

332 P {oh it's } ↑legible

For both goals set in the extract, the therapist first elicits problems from the patient - things that he cannot do. Secondly, she formulates the problem as the basis for a goal – something to be achieved in the future. Initially the patient's activity is 'synchronous' with the therapist's: he provides a problem. But when the therapist proposes and seeks agreement with a goal to remedy the problem, this is not forthcoming. Instead the patient asserts that he *is* able to perform the activity which the goal implies he is unable to do. In these responses he seems to orient to avoiding exposing and asserting physical incompetence. Hence it seems that soliciting patients' views on their problems within the process of goal-setting may not co-exist well with orientations to avoiding exposure of incompetence.

One further difficulty for the therapist that is evident in this extract is worth noting. Professional recommendations (ACPIN, 1995) urge that goals concern targets that are measurable. One of the goals set in the extract and upon which agreement is achieved is: **for you to be happy with yer signature maybe in a week** (340). This goal is compatible with the patient's apparent views on the nature of his problem. However, 'being happy with' something is not easily measurable. Thus, setting goals which closely relate to patients' concerns may be incompatible with setting goals that are measurable. This provides support for Wade's (1999c) contention that goals should not necessarily be confined to ones which are measurable because many relevant goals concern elements that are not feasible or practical to measure.

One final extract shows how once set, goals can be referred back to, so as to form the rationale for proposed activities.

S1Ph1PaGT1/11.22

This extract is comes from the same session in which the socks and writing goals were set. The patient is sitting on the treatment bed, his feet on the floor. The therapist sits at his right side, and holds his arm, flexing and extending it. The patient appears to lean towards the therapist slightly, she verbally encourages him to sit straighter, and touches his side. She closely follows her instruction to straighten with an explanation for why this is being asked:

- 1 T ... if you grow ↑taller and you could start learning to
 2 T be a- feel a bit ↓taller °h you'll find it ea::sier to reach forwards
 3 (.)
 4 T alright than when you're quite slumped
 5 (.)
 6 T so we can °h there ↑will be a purpose for °h learning to be
 7 a bit taller I think
 8 T (0.5)
 8 T alright to achieve that ojet- objective of reaching for yer socks

Thus, an activity is depicted as having a purpose because it contributes to achieving a previously talked about goal (see also S1Ph1PaBT2/11.08, line 13, Chapter 4 and Volume 2).

6.6 *Summary: interaction about reasons, purposes and goals*

Therapists and patients communicate about the reasons, rationale and purpose underlying therapy and its activities at some point in virtually all the recorded treatment sessions. There is some variation between therapists as to how often they introduce talk about the topic. However, on the whole it does not arise 'routinely' in the way that talk about *what* is to be done and *how* it has been performed does. Sometimes it arises at beginnings or ends of treatment sessions, alongside proposals of forthcoming activities. Very occasionally it arises alongside instructions for activities. Other than this, it arises only in 'special' circumstances entailing therapeutic troubles - of patients' responsiveness and achievements, or interactional troubles such as failure of understanding and expression of 'negative' affect. In these circumstances especially, the topic seems associated with an orientation to motivating and encouraging patients' efforts and participation.

The sorts of reasons that are talked about include shortfalls in patients' abilities, and technical or functional therapy-based reasons e.g. achieving weight-bearing or muscle activity. Talk about rationale often carries assumptions that the overall aims of therapy concern achieving more 'normal', 'proper' and independent movements. All talk on reasons and rationale assumes that progress, i.e. improvement in patients' physical abilities, is possible. Also that this is contingent upon appropriate therapeutic efforts. Nearly always, therapists introduce and do most of the talking on the topic. Sometimes patients contribute, and thereby display their own understandings. On the very rare occasions when patients request information about reasons, they do so tentatively and ambiguously.

Goal-setting is rare in this data collection, despite professional recommendations that goals should be set and regularly reviewed with every individual. This finding is consistent with those of interview studies (Payton et al., 1998, Partridge, 1994) and observational research (Talvitie, 1996) on neurological physiotherapy. In the current study, occurrence of interactions about goals and goal-setting varied considerably between the four sites and eleven therapists. Although the sample is too small to draw general conclusions, this suggests the existence of wider variations in practice⁴⁷.

Goals are formulated as targets for improvements in patient's physical capabilities. Sometimes, the therapist introduces (or imposes) the particular

⁴⁷. This would be consistent with previous findings that clinicians (this time nurses) vary in their use of goal-setting with stroke patients (Lawler et al., 1999).

capability to be targeted, other times, this is elicited from the patient by seeking their views and preferences. In these data it is invariably the therapist who formulates the goal and the time within which it is to be achieved. Once set, goals are sometimes re-invoked so as to provide a rationale for proposed activities. Extracts illustrated that when a patient's preferences and views of their problems are sought, and attempts made to incorporate these into goals, various interactional challenges can arise. Patients may express reluctance to provide topics for goals, and it can be difficult to elicit topics that are manageable through therapy. Thus, some topics for goals that are proposed by patients are not accepted by therapists. Accounting for this non-acceptance can take considerable interactional time and effort. Once patients' views have been elicited, there can be difficulties in achieving alignment on the nature and scope of the problem, and hence in gaining agreement with any proposed goal.

6.7 Interactional consequences and effects of talking about reasons and goals

As noted, an expectation of progress is intrinsic to talk about reasons and goals. Therefore talk on the topic is inherently encouraging and functions as a persuasive strategy. Therapists' orientation to this is apparent in the way they invoke and topicalise reasons at times when there are problems or potential problems of patients' participation and effort. The verbal agreements and commitments to participation that patients often give during these interactions provide evidence of the interactional effectiveness of this strategy.

Interactions about reasons and goals are also occasions on which therapists' authority, and patients' and therapists' orientations to it, are asserted and affirmed (c.f. Peräkylä, 1998). In talking about why activities are being performed or requested, therapists explain and account for their authority to instigate and direct activities. In doing so, they treat patients as capable of reasoning, of making rational choices. Patients usually acknowledge and agree with therapists, express commitment to proposed actions and goals, and do not question therapists' explanations and proposals. In this they display and confirm their orientation to therapists' authority. Indeed, if patients did not accept and align with therapists' goals and reasoning, and hence their authority and expertise, therapy itself would be undermined. Collaborative orientation to therapists' authority and expertise is a necessary condition for accomplishing explanations and for setting goals.

We noted earlier that advocates of goal-setting claim that it enhances patients' involvement in treatment decisions and activities. Our data provide evidence that interactions about goals, and also about reasons, can function to involve patients by providing opportunities for them to express their views and perspectives and for these views to influence what is said and done in therapy. However, goal-setting and explanatory talk do not *guarantee* enhanced patient involvement: the level of patients' involvement in these interactions varies, and depends on *how* explanations are given and goals set. Often in these data, opportunities for 'independent' expression of these perspectives and for contributions by patients are very limited. Also, when

therapists talk about rationale and overall aims of therapy they often *assume* shared aims without any apparent elicitation or confirmation of patients' views.

Further interactional consequences of the way therapists and patients communicate about reasons and goals relate to the way these topics tend to require lengthy spoken turns. Interactions about rationale and goals concern abstract ideas or future achievements and activities. As Goffman (1981) noted, talk rather than 'nonlinguistic resources' is needed where accounts are provided and actions in the future or elsewhere are requested or discussed. Therefore it is unsurprising that interactions about reasons and goals are primarily 'talk driven' (Jordan and Henderson, 1995). As noted elsewhere in this thesis, and in other research on interactions involving embodied actions, talking about reasons underlying activities often disrupts or precludes continuation of the embodied actions themselves (Weeks, 1996), and more generally, talk about other topics rather than the specifics of the physical activity itself can draw attention away from it (Frankel, 1993). In our data, topicalisation of rationale and goals did not coincide with performance of physical treatment activities: in general, the talk occurred during rests or breaks from physical activities, or prior to their commencement. Put simply, there is a trade-off between doing physical treatment activities, and talking about the reasons and aims that underlie them.

6.8 *Limitations of the scope of analysis within this chapter*

Limitations of the study as a whole are discussed in the following chapter. However, some are specific to this topic, especially to interactions about goals. Limitations on the scope of analysis in this chapter were presented by the small number of recorded interactions on these topics, particularly goal-setting. Ethnographic observations and conversations during the study indicated that goals are discussed in other places besides treatment sessions. These include case-conferences, patients' conversations with other staff members, and with therapists on the ward rather than in the gym. Also, it seems possible that the overall rationale and aims of physiotherapy would be discussed most explicitly during therapists' earliest contacts with 'new' patients, and our data include few of these first contacts. There is also evidence from some of the recordings that goals have been discussed and set previously. More comprehensive data on goals and goal-setting would require a different design for data collection to that used in this study.

Because of these limitations, it is not possible to make definitive propositions about the full range, variations and extent of practices in this area of communication. However, our data are sufficient to allow description of locations in which talk about rationale and reasons *are* recurrent. They are also sufficient to allow examination of procedures and difficulties entailed in talk about reasons and goals, and interactional practices and strategies used to deal with these difficulties. Furthermore, the infrequency of talk about reasons and goals we observed is an interesting finding in itself – indicating that such talk does not pervade all sessions.

6.9 *Explanatory analysis of the observed patterns of conduct*

In view of the analysis above, several questions arise. These include:

- Why are reasons, purposes and rationale topicalised relatively infrequently, and goals very infrequently?
- Why are these topics mostly initiated and talked about by therapists rather than patients?
- Why do most of the observed interactions about reasons and goals entail very limited elicitation and incorporation of patients' views of their problems and needs?
- Why do people (patients) tend to express a strong desire for explanations and for involvement in goal-setting during interviews and focus groups, but not in actual interactions with therapists?

The first question concerns the infrequency of interactions about reasons and goals. Several possible contributing factors have been alluded to throughout the text and are brought together here. One possible factor is the trade-off between time spent on focused talk about goals and rationale, and time spent performing physical activities: the more therapists and patients talk about the topic, the less time there is for physical activities. The way that shortcomings of patients' abilities need to be brought to the interactional surface in order to establish reasons or goals may also contribute to the low frequency. More talk on these topics would entail greater exposure of patients' physical incompetence, an activity often avoided during sessions. Another factor is that all explanatory and goal-setting talk assumes that progress is possible. If there is some doubt about a patient's potential for

progress, therapists may not introduce talk about rationale or goals. A further factor is that therapists usually seem to treat underlying reasons and rationale as routine and assumed matters and therefore do not raise them. Thus we only see interactions on reasons and rationale in specific circumstances. At other times, it may be that the reasons for a treatment action may be intelligible without talk because of the local sequential context. However, the degree to which a patient *actually* understands is difficult for analyst and therapist to discern if the topic is not verbalised, because lack of understanding is only rarely manifest in patients' conduct. Finally, patients very rarely introduce this topic. That is, they do not ask therapists to explain.

This brings us to the next question, which concerns the differential contributions of patients and therapists to instigating and talking about reasons and goals. Inequalities of knowledge are likely to contribute to this. Therapists have greater knowledge than patients do about the effects and recovery patterns of stroke, and this informs their setting of goals. Therapists also have greater technical and professional knowledge of the rationale of therapy. Patients may simply not possess the knowledge to set goals and talk about rationale. However, as Drew (1991) shows, people may not display knowledge even if they possess it because of orientations concerning what sort of knowledge they are expected and entitled to claim. For instance, several times in the data, patients initially resist producing evaluations of their own abilities, though they eventually do so. That is, it becomes apparent that they have knowledge, but orient to not claiming or exhibiting it. Thus, therapists' greater technical knowledge is one factor in differentials between

therapists' and patients' contribution to explanatory and goals talk, but patients' reluctance to exhibit knowledge is another. A related factor which also affects who says what in these interactions is that patients may avoid actions that expose wider incompetence. While exhibiting physical incompetence may be unavoidable, patients may attempt to avoid exposing any lack of knowledge or cognitive competence (see S3Ph4PaMT1/1.50 in Chapter 5). Thus patients may avoid asking a therapist why something is being done because this can imply failure to understand what is going on.

Further insights into this question might be gained from other research which has examined interactions in which co-participants ask for explanation of reasons underlying one another's actions. However, there is little literature on this, perhaps reflecting the infrequency with which it occurs.

Nevertheless, seminal work by Garfinkel (1967) in his breaching experiments provides empirical evidence about people's orientations to asking co-participants to explain the meanings of their actions. The following discussion of some of these experiments and their interpretation draws on descriptions and commentary by Heritage (1984, Chapter 4).

Heritage describes Garfinkel's work as pursuing the question: "how do social actors come to know and know in common, what they are doing and the circumstances in which they are doing it?" (p76). In various experiments, the ways that people routinely make sense of their circumstances, and particularly of one another's actions were investigated. The experiments deal with many questions beyond our current concerns, and their implications

regarding social organisation and intersubjective understandings are complex and far-reaching. The present account and discussion will confine itself to the question: why do interactants (patients) rarely ask their co-participants (therapists) about the meaning of their actions?

In one experiment, Garfinkel instructed his students to: “engage an acquaintance or friend in an ordinary conversation and, without indicating that what the experimenter was saying was in any way out of the ordinary, to insist that the person clarify the sense of his commonplace remarks” (Garfinkel (1963, p 221) in Heritage, 1984). It was found that experimenters’ ‘What do you mean?’ questions resulted in “extraordinarily rapid and complete” interactional breakdowns (p80), seen in responses such as: “What’s the matter with you? You know what I mean”, and: “You know what I mean! Drop dead!” (p80). Thus, subjects treated what experimenters said as ‘breaches’ and these were “very rapidly and powerfully sanctioned” (p81). This experiment showed that, at least during ‘commonplace’ conversations, people take for granted and trust that their interactional co-participants will supply whatever understandings are needed in order to make sense of what is said. Further, it showed that breach of this trust is met with strong sanctions. Garfinkel thus noted that in two-party conversations, “much that is being talked about is not mentioned, although each expects that the adequate sense of the matter being talked about is settled” (Garfinkel (1963, p221) in Heritage, 1984). The experiment showed that people trust in one another’s ‘reciprocity of perspectives’.

This experiment concerned everyday conversations relating to ‘what everyone knows’; the physiotherapy situation is different. That is, patients, especially those in early stages of rehabilitation, would be unlikely to be able to furnish their own understandings of what is going on, at least within certain boundaries⁴⁸. Thus in the current study, on the rare occasions when a patient asked for clarification of meaning, we do not see the sort of hostile response evident in Garfinkel’s experiment. The therapist does not sanction the patient, but instead provides lengthy explanation. That is, the therapist does not display expectations that the patient *should* understand.

Nevertheless, even though there is no evidence that they are sanctioned for ‘asking why’ patients very rarely do so. We argued above that it is unlikely that this is because they have full understanding. Instead we proposed that this interactional pattern is associated with orientations to avoiding exposing incompetence, and with the way that the rationale for participating in physiotherapy must rest on maintaining a collaborative orientation to the authority and expertise of the therapist. We will explore this further by returning to Garfinkel’s experiments, one of which concerned interactions between ‘providers and recipients’ of ‘professional’ services.

⁴⁸ It would be logical to expect that therapists’ lack of sanctioning and willingness to explain operates within certain limits. Areas of knowledge which patients would not be expected to have must relate specifically to aspects of therapy, thus asking ‘why questions’ concerning more ‘mundane’ knowledge might well result in conduct more similar to that seen in Garfinkel’s experiment. It might also be predicted that as a patient’s physiotherapy career progresses, a therapist would expect their knowledge about therapy to increase, and thus were the patient to ask questions about basic aspects of therapy at that point, sanctioning of such questions by the therapist might be seen. (See Chapter 4, Section 4.1 and footnote 1).

The recipients' conduct in the experiment shows that people do not directly question professionals' actions but make sense of these through other mechanisms. Indeed, in large areas of life and interactions, people do not generally establish understandings through explicit topicalisation of what some action or talk means. They do so through some other form of sense-making mechanism. This is the 'documentary method of interpretation', which was investigated within the breaching experiments.

Garfinkel described the 'documentary method of understanding' as follows: "the method consists of treating an actual appearance as "the document of" as "pointing to", as "standing on behalf of" a presupposed underlying pattern" (Garfinkel (1967) in Heritage, 1984, p78). The workings and implications of this mechanism are complex and far-reaching, but we will maintain a focus on our particular question. In Garfinkel's 'student counselling experiment', students were asked to describe some personal problem to a 'counsellor', then ask them ten questions about it. These had to be questions which could be answered either 'yes' or 'no'. The student sat in a different room to the 'counsellor experimenter' and the rooms were connected by an intercom. Unbeknown to the subject, the counsellor's yes or no answers were determined by a random number table. The student subjects were asked to record their reflections and to summarise the exchange as a whole. It was found that the subject 'made sense' of the counsellor's answers, imputing reasons and intents to the counsellor, even where their answers seemed incomplete, incongruous or unsatisfactory. Thus, the counsellor's answers

were treated and interpreted as “the trustworthy products of properly motivated advisers” (p92).

Our argument here is that patients likewise generally treat therapists’ actions, their instigation, proposal and direction of treatment activities, as ‘trustworthy products of motivated physiotherapists’. Patients rely on documentary interpretation in order to make sense of physiotherapy: building understandings about the underlying ‘pattern’ and nature of physiotherapy from individual occurrences, and interpreting individual occurrences on the basis of what they have already experienced, rather than constantly asking for reasons and explanation. Further, asking for reasons and explanation could imply questioning of the therapist’s trustworthiness and motivations, and is therefore avoided or done tentatively.

We have suggested that therapists initiate and talk about reasons and goals because this acts as a strategy for persuading patients to participate in therapy and for attaining expressions of commitment to do so. We have also suggested that therapists possess technical knowledge and ‘rights to display knowledge’ that allow them to talk about the topic in ways that patients cannot and do not. In the foregoing discussion we turned from why therapists *do* initiate and talk about the topic to why patients on the whole *do not*. We have argued that the rarity with which patients initiate the topic does not reflect their level of understanding, rather that it reflects their orientations to the authority and expertise of the therapist and to avoiding exposing their own lack of competence. The breaching experiments further illustrate ‘good

reasons' for patients not to seek clarification of meanings and reasons from therapists. Their conduct seems to reflect broader social orientations to when and whether people ask co-participants to explain the reasons underlying their actions and talk. Garfinkel showed that people routinely treat their own and each other's actions as the chosen products of knowledgeable agents, and coupled with this, questioning those actions has the potential to imply that the person's motivation and knowledge are being challenged. It seems reasonable to propose that as well as shaping patients' conduct, these orientations also shape therapists' conduct. Specifically, the way therapists do not routinely explain their therapeutic activities reflects the way people generally expect one another to understand the meanings of actions through the documentary method of interpretation rather than through direct verbal topicalisation. Although a further limitation on therapists' explanatory talk may be their judgements about what patients need to understand.

The third question posed above asked why most observed interactions about rationale and goals entail limited elicitation and incorporation of patients' views. We have already answered this at some length during analysis of the extracts and so will only briefly reiterate. When therapists elicit patients' perceptions they risk exposing problems which cannot be dealt with within therapy. As extracts showed, this can entail demanding and lengthy interactional management. There is also evidence in the data that patients show reluctance to state their views. Therapists sometimes manage this by asking repeated questions and pursuing a response. Further, even when a patient's views have been elicited, it can be difficult to build shared

understanding and hence agreement about associated treatment plans and goals. Two strategies by which therapists manage these difficulties were described. First, they may elicit patients' views in such a way as to substantially constrain the sorts of problems that are 'allowable'. Second, therapists may themselves 'name' the problem and/or assume the patient's view and aims. Both strategies circumvent some of the interactional difficulties which 'involving' patients can entail, but also limit the patient's 'active' contribution to the processes of talking about reasons and setting goals.

Our final 'why' question arose from the strong desire for explanations and involvement in goal-setting that are expressed in some interviews and focus group studies (e.g. Partridge, 1994). These findings have been influential upon formulation of recommendations for practice (Mead, 2000). Our question concerned why this orientation is not so apparent in actual therapist patient interactions such as those we observed; patients sometimes exhibit reluctance and reticence with respect to involvement. An answer can be found in Murphy et al's (1998) comment that interviews are:

"occasions when individuals feel called upon to give accounts of their actions, feelings, opinions etc., in such a way as to present themselves as competent, and indeed moral, members of particular communities. For example, the interview may be experienced as an occasion on which to display adequate patienthood." (p120)

Thus, in interviews and focus groups, patients are highly likely to express a preference for being informed and involved in treatment decisions and goal-setting: in doing so, they portray themselves as good patients, keen to co-operate and make efforts. However, in actual interactions with therapists, other orientations seem to come into play. These include the dispreference for asking a co-participant to explain the meanings of their actions, and avoidance of actions which might be taken as questioning the trustworthiness, motivation and expertise of the therapist.

6.10 Relationship between observed practices and the recommendations for practice

Therapists are urged to “ensure that the patient is fully involved in any decision-making process during treatment planning” (CSP, 2000, Standard 8.1) through facilitating dialogue and providing opportunities for communication with patients, and expression of their views (Mead, 2000). Published recommendations state that goals should be set for each patient, and “established by negotiation” (CSP, 2000, Standard 8.4), “negotiated and agreed” (ACPIN, 1995, p15), also that the goal, or at least the time-scale for its achievement are “subject to on-going review, discussion and modification” (CSP, 2000, Glossary). Goals should be “appropriate, measurable, achievable and functional” (ACPIN, 1995, p15).

As throughout this thesis, comparing observed practices with the recommendations is not straightforward because the recommendations are abstract. Therefore, determining precisely what would and would not

constitute 'recommended conduct' is difficult. For instance, the degree of negotiation and of patient involvement and agreement with respect to goals and explanatory talk varies considerably across instances in the data, and the recommendations do not specify a 'correct' level. A further difficulty concerns the limited data available in this study: any talk about reasons and goals that did not take place during the recorded sessions is unavailable for analysis and comparison with recommendations.

Despite these difficulties, some reflections on the recommendations in the light of the data are possible. First, the recommendations imply that goals should be set for each individual patient, and should be regularly reviewed and discussed. The low frequency with which the topic arises is noticeable in the data, even though recordings spanned patients at various stages of rehabilitation from admission to discharge, and usually included four sessions with each patient. Second, patients' involvement in talk about rationale and goal-setting varied in the data. In some sequences, patients' only contributions were minimal acknowledgements of therapists' proposals and announcements, in others, patients' views, including their perceived problems, were elicited and formed the foundation upon which goals were set. Likewise, some interactions about reasons and rationale of treatment activities involved opportunities for patients to express their understanding, but in others these opportunities did not arise.

Turning specifically to goal-setting, both 'common sense' and the data suggest that the degree to which goals can be 'negotiated' and 'agreed' with

patients has limitations. Not all problems that are significant to patients can be approached and resolved in physiotherapy. Likewise, patients lack the technical knowledge to specify and set appropriate and achievable goals and to prescribe treatment activities by which to achieve them. Although it may seem facile to spell out these limitations to patients' involvement in goal-setting, we do so because these constraints are largely ignored in writings about 'shared decision making' and goal-setting.

In summary, there are constraints on the frequency with which reasons and goals are topicalised, and on patients' involvement therein. These have been illustrated through data extracts and explored in analysis. For patients, there is a dispreference for asking therapists to explain their actions, which links with an orientation to therapists' authority and expertise. Patients may be reluctant to 'put their view' because of asymmetries of knowledge and because of orientations to avoiding exposure of any lack of understanding. All these factors tend to restrict patients' instigation of and contribution to talk about reasons and goals. Factors which appear to constrain therapists' talk on these issues include their treatment of many physiotherapy activities as routine and either understood or at least not requiring explanation.

Therapists also tend to minimise reference to topics that entail direct indication of patients' physical incompetence. A further factor may be the time required for building understandings about reasons and rationale and for eliciting and incorporating patients' views and preferences within treatment decisions and goals, and the fact that doing so may interrupt physical treatment activities. The assumption of progress inherent to goal-setting and

to much explanatory talk may limit talk on these topics where a patient is seen as lacking potential for progress.

All these factors limit the implementation of those recommendations that urge therapists to involve patients by explaining activities to them, providing opportunities for expression of their views, and setting goals.

Finally, we consider the capacity of certain specific practices we described to meet both the demands of the interactional constraints of this particular situation and to fulfil the recommendations themselves. Talking about reasons underlying activities and about treatment plans and goals appears to be effective as a persuasive strategy and can provide opportunities for patients' interactional involvement in sessions. Interactions on these topics can thus form an opportunity for patients' expression of their own views, as is recommended.

In just a few of the recorded sessions, a pattern is seen where a therapist frequently refers to the reasons underlying proposed activities. They do so in the main by providing brief explanations alongside instructions, a practice seen within the first extract in this chapter (also in S1Ph1PaBT2/11.08, Chapter 4). This suggests that it is possible to provide explanations to patients without major disruption of the physical treatment activities.

In some extracts, considerable patient contribution to explanatory and goals talk was evident. In these, therapists solicited patients' views of their problems and aims, and tailored goals and explanations so as to fit these. The extracts showed that this requires skilled practices on the part of the therapist, and can require substantial time and effort. The skilled practices include questioning techniques that constrain the sorts of problems solicited, perseverance in establishing shared understandings about those problems, and persuasive argument to achieve agreements with patients.

In the light of some of the interactional difficulties apparent in the data, it is possible to suggest some further practices that might meet the 'requirements' of both the recommendations and the situational constraints of physiotherapy. However, since these practices did not occur in the data, we can only speculate as to their feasibility or effectiveness. First, greater clarity and mutual understanding might be fostered by therapists if they explicitly communicated with patients about the constraints upon the sorts of problems dealt with in therapy – i.e. the limits of therapy. Greater interactional synchrony between therapists and patients might ensue if therapists explicitly described the process and functions of goal-setting to patients. Finally, therapists could avoid treating so many of the things they do and say to patients as mutually understood and instead more frequently explain what they were doing and why.

Returning from speculation to the empirical findings in this chapter, these make it clear that explaining activities to patients, eliciting and incorporating their views, and setting goals are demanding and potentially time-consuming activities. It would be easy to overlook the powerful constraints and social orientations that shape the contributions that patients and therapists make to these interactions. Yet acknowledging and understanding these constraints and orientations could provide more practice-relevant information about explaining activities to patients and goal-setting, and could provide a basis for more specific and feasible recommendations. We discuss this argument further in the next and final chapter of the thesis.

CHAPTER SEVEN

DISCUSSION AND CONCLUSIONS

7.1 *Introduction*

In this chapter we review the findings and insights gleaned from this study's analyses, and discuss the relevance and utility of its topics and methodology. The chapter is divided into two sections. The first section summarises findings from the three analytic chapters; reflects on how these relate to previous findings and assertions concerning physiotherapy communication; and discusses the utility and potential of conversation analytic studies in physiotherapy research and practice. We will also consider the scope and generalisability of this study's findings. In the second section, we examine the study's insights and contributions to ethnomethodological and conversation analytic research and knowledge. In doing so, we discuss one particular aspect of our methodology: the comparison between actual practice and published professional recommendations. We will argue that this is a valuable method for researching therapeutic interactions. This second section will also highlight the contribution our findings make to the body of conversation analytic knowledge about healthcare / therapeutic interactions.

7.2 *Insights and implications for physiotherapy practice and research*

7.2.1 Interactional practices during physiotherapy treatment sessions: summary of findings

Chapters 4, 5 and 6 explored communication between physiotherapists and patients with respect to how they interact, and develop and display understandings about:

1. The nature of treatment activities and of participation therein
2. Achievement (success and failure) in these activities
3. The reasons, goals and purposes underlying the activities

Analysis concentrated mostly on one-to-one therapist patient interactions, although we acknowledged that physiotherapy can also entail other modes of interaction.

We will now summarise our findings in a condensed form. For illustrative extracts along with full descriptions of practices, and for explications, argument, and referencing about these practices and the orientations that underlie them, the relevant chapter should be consulted. Here we summarise the practices observed, their interactional functions and effects, the orientations apparent in them, and the relationship between conduct observed in these data and the published recommendations for good practice.

In this summary, when we refer to “patients’ and therapists’” conduct, practices and so on, we are referring specifically to the patients and

therapists recorded in the data of this study. Issues of generalisability are addressed later.

7.2.1.1 Communication about the nature of treatment activities and participation (Chapter 4)

Throughout our analyses we saw, unsurprisingly, that therapists' and patients' tasks and interactional activities differ. In the first chapter, we examined 'instruction-response sequences', which occur throughout treatment sessions. We found that therapists initiate and direct activities, convey to patients the nature of therapy activities, and of expected participation in them. Patients generally respond to therapists' instructions and convey their alignment and co-operation. They respond promptly to instructions, using body movement, facial expression and vocalisation to convey effortful participation, they show keenness to 'get it right' – checking this with the therapist through gaze and questions (*c.f.* S1Ph1PaBT2/11.08, Chapter 4 and Volume 2⁴⁹). They tend not to question therapists' instructions, and mostly avoid instigating or determining activities themselves.

It is generally the therapist who appears to determine what, when and how activities are performed. We observed a restriction on patients' verbal

⁴⁹. As throughout this thesis, we cross-reference extracts that can appear in several locations throughout Volume 1 and also in Volume 2. For this reason, giving page numbers would be very cumbersome. Precise locations can instead be found in the index for the relevant Chapter in Volume 1, and in the index of Volume 2.

comments about activities, and that they rarely initiate actions. We noted that the degree of this restriction varies depending on the type of treatment activity, particularly on whether the therapist is touching the patient. Patients' talk appears more constrained when activities involve physical guidance by the therapist than when movements are performed with the therapist's 'hands off'; patients' contributions are yet more constrained when the treatment involves actions performed upon the patient by the therapist. It seems that patients avoid taking any action that might be read as commenting on the performance and activities of the therapist. We proposed that this forms part of the way that the orientation to the therapist's authority and to upholding it is manifested.

This brings us to a consideration of the underlying orientations and functions of therapists' and patients' conduct. In treating therapists as leaders and orchestrators of therapeutic activities, patients exhibit orientation to therapists' authority to judge what counts as normal and competent physical conduct, and to determine how this is to be achieved. Therapists' actions also convey that their authority in this is assumed.

Besides an orientation to the therapist's authority, we showed that an orientation to dealing with physical incompetence in particular ways is also important in shaping therapists' and patients' conduct. This entails countering possible implications that physical incompetence is indicative of wider defects in competence and/or wilful lack of effort. In instruction-response sequences, this orientation was particularly apparent in patients'

actions. By these actions, patients convey a keen, co-operative participation, showing they are sufficiently competent to recognise that their conduct deviates from 'normality' and needs remediating, also that they are sufficiently competent and motivated to restore 'normal' physical competence through therapeutic efforts. Showing such motivation also counters the possible impression that current incompetence is intended or desired. Their actions included responding promptly to instructions, showing effortful tension in the body musculature and facial expressions during exercises, and glancing at the therapist or asking questions so as to elicit information about correct performance. Orientations to authority and 'good patienthood'⁵⁰ also underlie the way patients co-operate with, rather than question, therapists' instructions. Whilst this area of analysis highlighted elements of patients' conduct that attend to management of incompetence in particular ways, other areas of analysis, especially concerning management of failures of patients' performances, illustrated that therapists attend to the same concerns (see Section 7.2.1.2).

In explicating these orientations and the related interactional conduct, we drew on Parsons' influential analyses of physicians' and patients' behaviour, and his conception that patients' and clinicians' roles are constituted by permissions and privileges balanced with and contingent upon duties and responsibilities (Chapter 4, Section 4.4). In a similar vein, we found that

⁵⁰ The term 'good patienthood' was used in this study to refer to the configuration of patient behaviours by which they counter possible negative implications of physical incompetence (See Chapter 4, Footnote 14).

physiotherapists' and patients' conduct entails balancing various demands and contingencies. For instance, we noted that for physiotherapy to run smoothly, patients must exhibit sufficient incompetence to be perceived as in genuine need of therapy, but must also show sufficient competence to recognise 'abnormality' and make efforts to overcome it through personal effort. We also observed that therapists must balance support and understanding of patients with encouraging them to participate in effortful and sometimes uncomfortable physical activities.

However, we acknowledged that aspects of Parsons' analyses, particularly his conception of fixed, *a priori* roles and norms as governing conduct, are not consistent with ethnomethodological and conversation analytic understandings of how conduct is organised. Therefore, these aspects of his analyses are incongruent with the approach adopted in this study. Bearing such criticisms in mind, we also drew upon Goffmans' analyses of conduct, which are more clearly grounded in empirical observation and description of people's conduct, and which bear closer relations to ethnomethodological understandings of human interactions. His analyses emphasised the way that people engage in 'compensating modes of behaviour' so as to limit or counter implications of wilful and wider incompetence that arise when physical failures are apparent. A particular analytic focus of this study has been upon illuminating ways in which 'compensating for incompetence' influences conduct in physiotherapy interactions, thus Goffman's ideas were important influences throughout analyses, including our second topical focus, to which we now turn.

7.2.1.2 *Communication about achievement of treatment activities*
(Chapter 5)

This part of our analysis examined how, once treatment activities are underway, therapists and patients communicate about the success or failure of patients' performance of those activities. We observed that therapists produce evaluations of performance far more frequently than do patients. They produce positive evaluations during and following the majority of treatment activities and do so in a direct manner. Often these evaluations are brief and glossed, e.g. 'good', 'brilliant'; sometimes therapists go on to elaborate the criteria underlying these evaluations (e.g.S3Ph4PaMT1/1.41, Chapter 4 and Volume 2). Patients generally respond to rather than initiate positive evaluations. Their responses are usually brief acknowledgements and/or agreements. Positive evaluations are usually followed by repetition of the prior activity or progression to a next one. That is, they function to display that performance was adequate, and to project either its repetition or a move to some next activity.

When failures in performance become apparent, their interactional management is more complex than for successes. As prefigured in our discussion above, their management entails balancing opposing interactional demands, and is shaped by orientations to dealing with the potential implications arising from incompetence. For therapists, management of failures entails showing sensitivity to the potentially negative effects of making problems apparent whilst nevertheless attending to these problems

and instituting corrective action. The potentially negative effects include provoking patients' distress (as can occasionally be seen in the data) and demotivating them. Therapists reassure patients, minimising the problems and their implications. Their talk and actions imply an expectation that problems will be solved through patients' efforts within and alongside physiotherapy. That is, their interactional practices attend to patients' motivation and to maintaining the rationale of physiotherapy even in the face of failures in treatment activities, as well as to dealing with potential implications of incompetence.

Likewise, patients engage in complex interactional work when failures in performance are apparent: conveying awareness of their failures, and at the same time that they are not defeated by or resigned to them. They tend to show an apologetic or concerned demeanour (often saying 'sorry') in the face of failures of performance, and they make physical efforts to continue treatment, show compliance, alignment and agreement with therapists' evaluations and their repair actions and proposals. These actions convey that the problem was not intentional but was a 'genuine' failure. They also help counter possible implications of wider incompetence, because patients show they are sufficiently competent to recognise that their performance was problematic. We also saw that patients do not produce 'second assessments' in response to therapists' evaluations, as is the usual pattern in ordinary conversation between peers (Pomerantz, 1984a). In doing so they avoid claiming independent knowledge or authority to judge and evaluate performance.

On occasion, patients initiate direct negative evaluations of their own performance, which often serve to elicit reassurance from the therapist. These self-evaluations generally arise when the therapist is not touching the patient. This follows a more general pattern seen in the data, wherein the less physical assistance the therapist gives, the more likely a patient is to make interactional contributions, particularly spoken turns. As we have argued, patients' comments or evaluations have the potential to be construed as undermining and questioning the therapists' trustworthiness, motivation and expertise. Were a patient to produce negative evaluations during guided movements, these would in a sense evaluate the therapist's performance as well as their own, and implicitly criticise the therapist, undermining her authority.

Regularly, therapists solicit assessments from patients. These generally concern subjective aspects rather than 'objective' evaluations of the success or failure of performance. When patients are asked to evaluate success or failure, they often display reluctance to do so (e.g. Chapter 5, Section 5.7). While lack of knowledge might contribute to their reluctance, we suggested that there may be additional 'interactional reasons' for it. We proposed that these included the way conveying lack of knowledge and inability to judge establishes and maintains the therapist's authority as 'teacher' and the patient's role as learner, and hence maintains the underlying rationale of therapy. We also argued that patients can be reluctant to evaluate because of issues of competence. An 'incorrect' self-evaluation runs the risk of

revealing that the patient is incompetent to judge their own performance (S3Ph4PaMT1/1.50, Chapter 5).

Thus, the orientations that were apparent in instruction-response sequences (i.e. orientations to therapists' authority, and to limiting and countering negative implications associated with physical incompetence) also seem to shape conduct in this area of therapeutic interaction. However, additional orientations are apparent: these concern how evaluations of co-participants' conduct are produced and responded to. Previous CA research (Chapter 5, Section 5.2.2) has shown that in ordinary conversations, evaluations that disagree with or criticise one's co-participant are avoided altogether or else performed through dispreferred turn shapes⁵¹ (for instance with pauses or partial agreements prior to the stated criticism or disagreement). This pattern serves to minimise the occurrence of disagreement or criticisms, or to mitigate them if they occur. CA research has also found that when some form of performance error occurs in ordinary conversations, there is a preference for self-repair, with direct correction of one's co-participant being dispreferred. In physiotherapy, as in many other institutional interactions, critical assessments and other-repairs are often unavoidable, indeed they are prevalent. Nevertheless, in their conduct, participants orient to the delicacy and dispreferred nature of these activities.

⁵¹. However, there are exceptions: for instance, in responding to a co-participant's self-criticism, disagreement is *preferred*.

With these observations in mind, we now turn to specific practices by which therapists manage apparent failures of patients' performance. These practices can be pictured as occupying a continuum. At one end are direct 'blunt' indications of problems and repairs. At the other extreme, therapists remain silent even when problems are clearly apparent, or produce only ambiguous comments that avoid any evaluative and reparative components. Other practices we observed amongst therapists, and which arose with far greater frequency in the data, involve indirect management strategies that lie at various points between these two extremes.

Very direct indications and repairs of problems are rare in these data, and arise only in circumstances where patients appear to have *entirely misunderstood* the nature of the activity, rather than where they were actually attempting, though failing, to achieve the instructed activity (S2Ph3PaHT3/11.58 in Chapter 5, Section 5.4.1). Less direct indications and repairs can be broadly divided into sequences wherein therapists do not verbally refer to problems, and those wherein they do. The first form resembles the *embedded corrections* Jefferson (1987) described. In these, issues of incompetence are kept off the conversational surface. In our data, these occur when therapists institute reparative strategies without directly naming the problem. They do so through re-specifying or sometimes withholding further instructions, and/or through withholding ongoing positive assessments. Through these means, therapists encourage or 'clue' patients to perform activities differently, and can thereby implicitly indicate (rather than explicitly state) that prior performance was lacking in some way. A smooth

and 'discreet' change and correction of activity is often effected. However, this strategy does not allow for discussion of, or accounting for, the problem's cause. As a result, it does not provide opportunities for therapists to check patients' understandings nor for patients to seek information from the therapist about their performance. In our data, there were episodes where lack of opportunity for talk about shortcomings was observably problematic. This occurred when therapists' strategies approached the end of the continuum pictured above wherein they were so indirect as to avoid or make highly ambiguous evaluations (Chapter 5, Section 5.4.2). Such indirectness and ambiguity can be taken by patients as signifying unstated but negative evaluation (*c.f.* Pomerantz, 1984a) and can have the same effects as being very direct: with patients showing signs of distress, and seeking the therapist's evaluation in ways that convey anxiety and concern.

The other form of management entails directly naming the problem so that it becomes the interactional business at hand. This resembles the *exposed corrections* Jefferson (1987) described. As she proposed, these provide interactional opportunities to account for and explain problems of performance and associated remedy proposals. In this set of practices, therapists either initiate and provide the problem indication themselves (formulated so as to mitigate and/or minimise its seriousness), or they solicit an assessment from the patient before providing their own evaluation. The latter relies upon a pattern known as a *perspective display sequence* which has been found to be used in both ordinary conversations and in clinical interactions as an inherently cautious way of presenting one's report or view

(Maynard, 1989, 1992). Also, particularly in clinical interactions, it is so organised as to enable and prefer affiliation between participants' perspectives, and to function as a persuasive device for drawing a patient towards expression of alignment with the clinical view (Maynard, 1992).

In the perspective display sequence form of management, the therapist invites the patient's perspective on their performance, and attends to it in the subsequent production of her own. The therapist can thereby tailor her assessment to the patient's displayed understanding and receptiveness. These sequences provide an opportunity for dialogue with the patient about problems whilst still avoiding blunt problem indication. They facilitate (though do not guarantee) building of alignment and an environment of agreement in which motivated participation with remedies and repairs can be encouraged. However, we observed that patients' reluctance to self-evaluate can disrupt these sequences.

Mitigated and minimised assessments also allow the therapist to avoid directly criticising the patient, and thus to reduce their demotivating impact. Often, these assessments include positive components alongside the negative ones. Therefore this strategy functions to reduce implications of wider defects of competence that arise when incompetence is exposed. A similar function is served by the alternative accounts for failure therapists sometimes provide, whereby they depict factors other than the patient themselves as causing the failure, e.g. 'the leg', or 'the stroke' (e.g. S1Ph1PaBT2/11.15, Chapter 5 and Volume 2).

Another form of strategy by which therapists deal with problems of performance entails their pre-emptive management via the format of instructions. We observed two forms of this in the data. These were (a) instructions that forecast problems and thereby mitigate their impact if they subsequently occur, and (b) instructions that avoid stating an aim or endpoint of the task and thereby conceal any failure of achievement. Both formats allow the therapist to provide positive assessments of patients' competence, whatever their response. They attend to patient motivation by allowing the therapist to make positive comments about their performance.

7.2.1.3 Body movement in physiotherapy communication (mainly Chapters 4 and 5)

Body movements are both a main topic of and a major resource for communication about physiotherapy treatment activities. Although body movement practices were not the primary focus of analysis in this thesis, we made some preliminary observations. It seems that certain characteristics of body movements and touch are especially important for physiotherapy communication. One of these characteristics concerns the way that body movements can disambiguate the referents of talk and can add considerably to the amount of information conveyed, particularly with respect to physical phenomena. Gestures, physical guidance, touch and sometimes explicit physical demonstration form means by which therapists can effectively convey the complex, novel, and rarely-talked-about body movements they

ask patients to perform in therapy⁵². Second, body movements form a particularly subtle and tentative interactional resource, making them valuable when performing potentially delicate and/or disruptive actions. The tentativeness of body movements is partly due to the way they tend to be more “indefinite in their meaning and import” than many words (Schegloff, 1984, p291), and also because they do not oblige a response from a recipient in the way that, in most situations, verbal actions do. They can therefore be used by one interactant whilst the other is talking, conveying information without interrupting. For instance, in our data we saw that through body movements, a patient can indicate their effortful, keen activity without disrupting a therapist’s verbal instructions, corrections, and so on (Chapter 4, Section 4.2.1). This tentative feature of body movements is also apparent in the way that patients use such things as head turns and glances to seek further information from therapists without directly asking questions (S1Ph1PaBT2/11.08, Chapter 4 and Volume 2). As noted, asking direct questions of therapists is often avoided because these may not only interrupt the therapist’s activities, but may also potentially imply questioning of their authority and judgement. The tentative, non-disruptive quality of body movements also makes them a valuable resource in managing patients’ failures of performance. We saw that body movements can contribute to managing patients’ errors of performance without verbally referring to these

⁵². This ‘disambiguating’ characteristic of body movement facilitates communication when, as is frequent in physiotherapy, therapist and patient are not able to see one another’s faces (unfortunately, detailed examination of this was beyond the scope of this study).

errors, and hence they contribute to avoiding direct criticism of patients, and achieving smooth, 'discreet' corrections.

Body movements are also important in conveying participation and alignment during interactions. Shared or mirrored movements, particularly via touch, allow parties to establish and maintain common task orientations and foci of attention. Since physiotherapy is so centrally concerned with body movements, shared movements form an important element of developing and displaying mutual participation in physiotherapy.

7.2.1.4 Communication about reasons, goals, and purposes underlying therapy activities (Chapter 6)

Although there is some communication about the reasons, rationale and purpose underlying therapeutic activities in each of the 74 recorded sessions, it does not arise as frequently as talk about *what* is to be done and *how* it has been performed. It sometimes arises at beginnings or ends of treatment sessions, alongside proposals for forthcoming activities. Occasionally it arises alongside instructions for activities. Other than this, talk about reasons and purposes arises only in 'special' circumstances entailing *therapeutic troubles*, e.g. of patients' responsiveness and achievement, or *interactional troubles*, e.g. failures of understanding and expression of 'negative' affect. In these circumstances especially, the topic seems associated with an orientation to motivating and encouraging patients' efforts and participation.

The sorts of reasons for therapeutic activities that are talked about include patients' impairments, particularly shortfalls in abilities compared to pre-stroke levels; and technical or functional reasons, e.g. achieving weight-bearing. Talk about rationale often carries assumptions that the overall aims of therapy concern achieving more 'normal', 'proper' and independent movements (e.g. walking). Both therapists and patients in our data displayed these assumptions. In general, communication about reasons and rationale tends to assume that improvement in patients' physical abilities is possible, contingent upon appropriate therapeutic efforts.

Nearly always, therapists introduce and do most of the talking regarding reasons and rationale. Sometimes patients' contributions display their own understandings about these. On the rare occasions when patients request talk from therapists about reasons for activities, they do so tentatively and ambiguously.

We also examined interactions about goals. Goals concern targets for improvements in patients' physical capabilities; and talk about goals and goal-setting is one way of talking about why therapeutic activities are being performed or proposed, and about the reasons underlying treatment decisions. Consistent with several other studies of therapy communication, goal-setting is rare in this data collection, despite professional recommendations that it should be done with every individual patient and that goals should be regularly reviewed (CSP, 2000; ACPIN, 1995). Occurrence

of interactions about goals and goal-setting varied considerably between the four sites and eleven therapists in the study.

Since goals target improvement in some currently problematic capability, they rely on and are based on awareness and exposure of shortcomings in patients' abilities. Sometimes therapists introduce (or impose) the particular capability to be targeted, at other times, this is elicited from the patient. The latter pattern of goal-setting offers more scope for dialogue and 'involvement' of patients, because their views and preferences are sought and can be incorporated into goals. However, extracts illustrated that when a patient's preferences and views of their problems are sought as part of goal-setting, and where attempts are made to incorporate these into goals, various interactional challenges can arise (e.g. S1Ph1PaGT1/11.11, Chapter 6 and Volume 2). Patients may express reluctance to provide topics for treatment action, sometimes explicitly invoking the therapist's authority and expertise in accounting for this reluctance (e.g. S1Ph2PaFT2/1.38, Chapter 6). Also, since patients are likely to experience a great variety of problems associated with their stroke (not solely the physical ones on which physiotherapy concentrates), it can be difficult for therapists to elicit 'relevant' topics. This is particularly so if the therapist's initial problem elicitation is an 'open question' that allows for many possible answers. Thus, when therapists elicit patients' perceptions they risk exposing problems that cannot be managed within therapy, but which can nevertheless entail demanding interactional management (*c.f.* S1Ph2PaFT2/1.38, Chapter 6).

We argued that the problem-based structure of goal-setting leads to further difficulties during interactions about goals. As noted, both therapists and patients orient to countering possible implications of wider incompetence. One difficulty this presents for goal-setting is that patients' orientations to demonstrating their competence rather than their incompetence can lead to their disputing or 'denying' the physical incapacity for which the therapist is attempting to set a goal. Thus, even when some 'target' for goal-setting has been identified by a therapist or solicited from a patient, there can be difficulties in achieving alignment on the nature and scope of the problem, and hence in gaining agreement with any proposed goal (e.g. S1Ph1PaGT1/11.11, Chapter 6 and Volume 2). A further difficulty in goal-setting can arise because therapists are urged by professional recommendations to set 'objective and measurable' goals (ACPIN, 1995), and in our data, attempted to do so. Where a patient's concerns are about shortcomings that can only be measured 'subjectively' (e.g. being '*happier* with one's hand-writing' in S1Ph1PaGT1/11.11, Chapter 6), setting goals which closely relate to their concerns (as is recommended) can be incompatible with setting goals that are easily measurable (as is recommended).

Interactions about explanations and goals were relatively scarce in our data, and this was consistent with findings of other studies. Therefore our analysis sought to explain why this might be so despite the strong emphasis laid upon them in published recommendations. Drawing upon our descriptions and explications of data sequences, we proposed several contributory factors.

We noted a trade-off between time spent on talk about goals and rationale, and time spent performing physical activities. Indeed, this is part of a more general pattern: throughout the data, there are episodes where extended talk disrupts or precludes continuation of the embodied treatment actions, or at least draws attention away from them⁵³. As well as during 'goals talk', this was observable during interactions about the success and failure of performance of treatment activities: any more than cursory reference to shortcomings of performance, their causes and remedies, was associated with an interruption of performances whilst talk about them occurred (see Chapter 5, Footnote 3). Thus, one contributing factor to the low frequency of explanation and goals talk may be the time it takes to do so. Another concerns the way that talk on these topics entails exposure of shortcomings in patients' abilities, an activity generally avoided or minimised during treatment sessions. Further contributors include the difficulties of eliciting topics for goals and of gaining alignment on them. Also the way that explanatory and goal-setting talk assumes that progress is possible: if there is some doubt about a patient's potential for progress, therapists may not introduce talk about rationale or goals (*c.f.* S2Ph4PaMT1/1.37 and /1.40, Chapter 6). A further factor is that therapists seem to treat underlying reasons and rationale as routine and

⁵³. This may have some relevance to recommendations in neurophysiotherapy texts that therapists should not talk to patients during certain exercises (Chapter 2, Section 2.7.1). We would argue that such a 'blanket prescription' might not be conducive to ensuring patients' understandings about activities, but that there does seem to be some evidence that *lengthy* talk during physical activities does indeed disrupt them (see for example Chapter 6, Section 6.7).

assumed matters and therefore do not raise them. There is evidence for this in the way that interactions on reasons and rationale tend to occur in specific, often problematic circumstances. At other times, reasons for a treatment action might be intelligible without talk because of the local sequential context (why an exercise is being done is obvious because of foregoing actions and talk). However, the degree to which a patient *actually* understands reasons is difficult for analyst and therapist to discern if they are not verbalised. A final contributor is rarity with which patients introduce this topic. That is, they do not ask therapists to explain. We argued that this reflects their orientation to the authority and expertise of the therapist, rather than their level of understanding.

To further explicate this area, and particularly the lack of explanatory talk (despite professional recommendations that emphasise it), we examined the findings of Garfinkel's 'breaching experiments' (Heritage, 1984, Garfinkel, 1967). These provide empirical evidence about people's orientations to asking co-participants to explain the meanings of their actions during conversations with peers and with professionals. Garfinkel showed that in large areas of life and interactions, people do not generally establish understandings through explicit topicalisation of what some action or talk means. They do so through another form of sense-making mechanism. This is the 'documentary method of understanding', in which actual appearances are treated as "the document of" as "pointing to", as "standing on behalf of" a presupposed underlying pattern" (Garfinkel (1967) in Heritage, 1984, p78). One breaching experiment involved a 'sham' counselling session in which

subjects' questions were responded to according to randomised answers (rather than any counselling logic), and showed that people made sense of the advisers' answers even where these seemed incomplete, incongruous or unsatisfactory. They interpreted answers as "the trustworthy products of properly motivated advisers" (Heritage, 1984, p92). We argued that patients likewise generally treat therapists' actions, their instigation, proposal and direction of treatment activities, as 'trustworthy products of motivated physiotherapists'. Patients rely on documentary interpretation in order to make sense of physiotherapy: building understandings of its nature and underlying 'pattern' from individual occurrences, and interpreting individual occurrences on the basis of what they have already experienced, rather than constantly asking therapists for reasons and explanation. Further, asking for reasons and explanation could imply questioning of the therapist's trustworthiness and motivations and is therefore avoided, or only done tentatively. These features of the way people make sense of each other's actions and produce their own actions provide 'good reasons' for the low frequency of talk about reasons underlying treatment activities, whether initiated by therapists or patients.

A further question that was examined whilst analysing explanation and goal-setting talk concerned why some interview studies report that patients express a strong desire for explanations and for involvement in goal-setting, whilst in actual therapist patient interactions, patients regularly exhibit reticence and even reluctance with respect to such involvement (as was observed in our data). We explained that in interviews and focus groups,

patients are highly likely to express a preference for being informed and involved in treatment decisions and goal-setting because in doing so, they portray themselves as good patients, keen to co-operate and make efforts (*c.f.* Murphy et al, 1998, p120). However, in actual interactions with therapists, other orientations come into play. These include the dispreference for asking a co-participant to explain the meanings of their actions, combined with patients' avoidance of actions that might imply questioning of therapists' trustworthiness, motivation and expertise.

7.2.2 Reflection on previous findings and criticisms of communication in physiotherapy and rehabilitation

We will now address previous findings and criticisms that were summarised in the literature review (Chapter 2, Section 2.1.1.1). We noted that many of these are founded upon a conception of clinical interactions wherein professionals are viewed as unilaterally imposing their authority, and thus enforcing patterns of asymmetry in which patients are made passive, and their contributions to treatment interaction are constrained.

In line with this conception, therapists have been criticised for failing to provide patients with sufficient information and explanation about treatment and for failing to ensure that patients' views are sought and incorporated into treatment. The implication has generally been that the asymmetry of interactional activities seen during physiotherapy interactions is solely a product of *therapists'* communication practices. Related criticisms argue that therapists dominate patients, making them passive recipients of therapy and

not giving them opportunities to speak. This criticism seems to assume that if therapists stopped their domineering patterns of communication, patients would automatically and necessarily ask more questions, express their views more, and be more active in therapy interactions.

Our analyses have shown that patients' interactional contributions do indeed differ from those of therapists; that therapists generally initiate and direct treatment activities, and that patients' interactional contributions are constrained, especially with respect to spoken turns. We also showed that explanations about therapy activities are relatively infrequent in the data, at least compared to some other topics of interaction. However, ethnomethodological and conversation analytic studies, including this one, have found that the establishment of authority, with the asymmetry this entails is a *collaborative production which results from the interactional conduct of both clinicians and patients*, and also that interactional patterns are more complex than is sometimes portrayed. In our study, contrary to the claims of some critics, patients are regularly very active in conveying certain information to physiotherapists, particularly concerning their efforts in treatment activities. Even during activities such as joint mobilisations, which therapists perform upon patients, we saw that patients actively monitor activities, and actively place their bodies 'in the therapist's hands', rather than simply being 'passive recipients' (e.g. S1Ph2PaHT3/11.44, Chapter 5 and Volume 2). We also showed that patients themselves are regularly reticent and reluctant to take up opportunities to express their views and preferences during treatment interactions, even when therapists make active and specific

attempts to solicit these. That is, the patterns of patients' involvement and their interactional contributions are not imposed and enforced unilaterally by therapists, instead, the asymmetrical patterns observed result from collaborative activities by both parties, and furthermore, these patterns are not simple ones of patient passivity and therapist activity. We also proposed that there are 'good reasons' for patients to constrain their talk and activities. These centre upon establishing and maintaining therapists' authority, and the associated differential between the roles of therapist and patient, upon which the rationale for participation in therapy relies. There are also good interactional reasons for therapists, at least at certain times, to constrain their information and explanation-giving to patients. In doing so, they can avoid disrupting physical treatment activities, and also they avoid exposing patients' deficits and thereby avoid demotivating or distressing them.

Thus, underlying those criticisms which assert that therapists unilaterally impose asymmetrical patterns of interaction and fail to provide sufficient information and explanation, is a lack of understanding of the collaborative nature of interactional organisation. Also, a failure to consider that there may be good interactional and organisational reasons for apparently bad professional practice.

In other criticisms it has been asserted that clinicians impose therapeutic aims of 'normality' and functional independence upon patients. The evidence of this study is that these aims appear to be topicalised and shared by both patients *and* therapists. Also, physiotherapists have been said to

concentrate on patients' bodies and bodily complaints whilst either neglecting, or failing to integrate patients' social, personal characteristics and concerns into their communication. From our observations, it is certainly the case that physiotherapeutic activities and tasks mainly concern physical, bodily activities. However, in their interactional practices, the therapists appeared to integrate attention to patients' bodies *and* to their subjective selves. For instance, with sensitively designed instructions that allow for the possibility of failure to achieve activities, and through the delicate ways patients' failures were indicated and corrected, therapists shaped their communication about physical activities so as to attend to patients' likely personal and emotional responses in therapy.

7.2.3 Relationship between the practices we observed and published recommendations for good practice

Current published recommendations by the Chartered Society of Physiotherapy (CSP, 2000), the neurological physiotherapists' clinical interest group (ACPIN, 1995) and the UK Department of Health (DOH, 1999) were outlined within the Chapter 2 (Section 2.1.2). These place considerable responsibility on the clinician actively to establish mutual understanding between patient and clinician through provision of information and efforts to 'fully involve' patients in treatment processes and decisions (CSP, 2000). Therapists are encouraged to negotiate individual goals of treatment with patients, and review these regularly. Overall, a particular emphasis is laid upon seeking and incorporating patients' understandings and preferences

into treatment processes and interaction, and upon ensuring and encouraging patients' understanding and motivation for treatment.

In terms of the process by which these principles are to be achieved, the recommendations state that physiotherapists should involve patients in their own care by facilitating dialogue, ensuring shared decision making, and actively establishing and confirming mutual understanding. Also, that they should communicate openly, honestly, clearly and unambiguously with patients, and should provide them with relevant information and with opportunities to ask questions and express their own views and preferences. Further recommendations specify that a relationship of 'mutual participation' should be aimed towards, and dependence on the therapist avoided. Therapists' general attitude towards patients should be one of respectfulness, with patients treated as equals and experts in their own right.

Comparing actual observed practice with the stipulations of the recommendations is not without difficulty, because recommendations are by their nature abstract and general (see Section 7.7.1 for a detailed discussion of the difficulties). They do not stipulate specifics, such as describing the interactional patterns and practices that would constitute 'full involvement', 'mutual participation', 'shared decision making' and so on. Nevertheless, it is possible to explore the compatibility of practice with the *general principles* laid out in the recommendations. We found that whilst some observed practices seemed to represent implementation of the recommendations, others did not. We also proposed that 'good reasons' for practices that do

not reflect the recommendations can be appreciated. These reasons relate to the way that the recommendations sometimes conflict with aspects of the demands, preferences and dispreferences of social and clinical interactions, and also to conflicts between some of the individual recommendations.

The stipulations about patients' 'full involvement' provide one example of conflicts between recommendations and the social and clinical demands of physiotherapy interactions. As we have noted, throughout the data, patients' participation and involvement is constrained - rather than 'full' - in various ways. Social and clinical orientations regarding clinicians' authority, as well as general social orientations concerning the sorts of question one asks of a co-participant can be seen to act as constraints on patients' participation. Another example of how the circumstances and rationale of physiotherapy seem incompatible with certain recommendations concerns stipulations that patients should be treated as equals. Therapists' and patients' institutional tasks and activities differ considerably, with patients showing reliance on therapists' expertise and knowledge in directing, assessing and explaining therapeutic activities. There are thus good reasons for why therapists and patients are not, and do not treat each other as, 'equals'.

The above are examples of conflicting demands between the recommendations and the circumstances and prevailing orientations of physiotherapy practice. Conflicts *within* the recommendations were also apparent in our analyses, particularly in how failures of performance are dealt with and corrected. For instance, Criteria 12.2 and 12.3 of the Chartered

Society of Physiotherapy's 'Core Standard 12' state that therapists should "communicate openly and honestly with patients", and that all communication should be "clear, unambiguous and easily understood by the recipient" (CSP, 2000). Such proposals illustrate the unrealistic and simplistic assumptions about human communication that underlie such recommendations. Furthermore, even were it possible for therapists to communicate in this way when giving assessments and correcting patients' failures of performance, doing so would be liable to provoke distress and demotivation. Patients would likely perceive they were being 'told off'. Therapists would thereby contravene recommendations that therapists treat patients with respect, and not as children, and that they communicate in ways that will facilitate motivation. That is, in this area of therapeutic communication, there are good reasons for ambiguity and indirectness. (Although we also acknowledged that this can be 'taken too far': absence of therapist evaluations in the face of clearly apparent shortcomings of performance can itself result in patients' distress; and ambiguity can result in patients failing to understand they are being asked to do (e.g. S3Ph4PaMT1/2.09, Chapter 4 and Volume 2).

7.2.3.1 Specific practices which seem to balance the demands of recommendations and of the circumstances and constraints of physiotherapy interactions

Certain interactional practices observed in our data seemed to achieve a balance between demands of recommendations and of practical activities and constraints in physiotherapy. We review these now, whilst stressing that we are *not* proposing that these constitute 'good' or 'recommended' practices

that should always be used. Every situation is different, and has its own requirements, and as we have seen, every interactional practice has a complex range of functions and effects. It is therefore not appropriate to make such prescriptions about communicative practice, an issue we return to later in this discussion. However, it is possible to take the general principles laid out in professional recommendations, and to explicate how interactional practices can contribute to these whilst at the same time attending to recurrent social orientations, i.e. to the ways that people routinely behave. We can also examine the effects of certain interactional practices and propose how these can be managed so as to attend to the stipulations of the recommendations. For instance, we noted how patients' involvement is more limited during treatment activities where the therapist is touching the patient, whereas when therapists' hands are off, patients tend to ask more questions and express their own views more. Whilst one might therefore suggest that physically guided activities should be avoided, tactile guidance of patients' movements, and performing certain activities *upon* patients (such as mobilisations) are often vital elements of treatment. Therefore, it seems more practical and appropriate to suggest that if therapists wish to maximise patients' interactional involvement in terms of asking questions and making other verbal contributions, then they need to be aware of how different activities affect, and can constrain, patients' interactional contributions to the activity. Therapists can then choose to provide opportunities for patients to contribute at times and in situations where they are likely to do so, e.g. in rest breaks between physically guided activities.

Various practices described in Chapter 4 (i.e. those occurring during interactions about participation and the nature of treatment activities) seem to contribute to enactment of the recommendations. These include acknowledging and attending to patients' indications of their participation, which, though usually non-verbal, are a form of involvement and of expression of their perceptions. Thus, through attention to these, therapists can treat patients as participating individuals, encourage their involvement, and constitute participation as mutual. These acknowledgements also form one of the ways by which therapists can help patients understand what is expected of them in physiotherapy treatment.

In our second analytic area: interactions concerning evaluations of patients' performance, we observed several aspects of practice that seemed to reflect recommendations. By soliciting and responding to patients' reports and assessments, therapists facilitate patients' expression of their views, treat them as experts in their own right, check their understandings, and facilitate mutual participation. As we saw, patients sometimes initiate self-critical assessments of their performance. When therapists respond to these with reassurance and by accounting for patients' problems in terms of non-personal factors e.g. 'the stroke', they deal with patients in ways that are respectful and that encourage their motivation.

The delicate management strategies by which therapists indicate and repair patients' failures can also contribute to enacting recommendations. The embedded form is effective in quickly repairing problems without exposing

and referring to them and potentially reducing motivation. Practices wherein patients' problems *are* named whilst still dealing sensitively with their exposure and correction have different effects. They provide opportunities for talk about problems and repairs, and thus can facilitate implementation of recommendations to increase patients' involvement in treatment processes and decisions, provide relevant information, and facilitate and check their understandings. We suggested that the 'perspective display' form of management is especially likely to increase patient dialogue and involvement because it allows therapists to treat patients as having knowledge and expertise which contributes to therapy, and allows for mutual participation in the identification of problems and in dialogue about them.

Actions by which therapists encourage patients during evaluation sequences are also in keeping with the recommendations to motivate patients. These include therapists' frequent positive assessments during 'successful' performances, and also actions which accompany problem indications, e.g. talk about overall progress or other areas of progress, general tone of voice, predictions of future success, and conveying expectations that problems are resolvable.

Our third analytic area concerned interactions about reasons underlying current and proposed activities and about treatment goals. These appear to be effective as motivating, persuasive topics. They represent information-provision to patients, and can provide opportunities for patients' involvement, although they do not automatically do so. One way by which therapists can

provide information about reasons is by giving brief explanations alongside instructions. Through this resource they can provide explanation to patients without major disruption of the physical treatment activities, thereby balancing somewhat conflicting demands within therapy. This was not a common practice in the data presented here. Therapists can also facilitate dialogue with patients by soliciting their views and understandings, and tailoring goals and explanations so as to encompass or be compatible with these. This was a somewhat more common practice in these data. We observed that doing so requires skilled practices on the part of the therapist. These skilled practices include questioning techniques that constrain the sorts of problems and aims solicited from patients; perseverance in developing shared understandings, and persuasive argument to achieve agreements. We also observed that these practices can require substantial time and effort, and thus can entail time spent talking to patients which is then not available for physical treatment activities.

Many of the above practices take time and skill to conduct. All require the therapist to be sensitive to the local interactional context, and rely on some knowledge of the effects of communicative actions upon patients' responses. Our contention is that conversation analytic research can identify those skilled practices and their interactional effects, and by making this knowledge available, can enable physiotherapists to make more reflective, 'evidence-based' choices between different communicative patterns and actions during physiotherapy.

7.2.4 Insights and implications for physiotherapy: discussion

7.2.4.1 *Generation of rigorous findings about the nature and effects of interactional practices in physiotherapy*

Our study has shown that by applying a CA approach to recordings of actual treatment sessions, recurrent patterns of interactional conduct in physiotherapy can be revealed and described in detail. In contrast to the categorising and counting approach so often used in the study of physiotherapy communication, this approach is able to capture the complexity of communication. We have been able to describe in detail different ways of performing certain activities within physiotherapy, e.g. giving instructions, demonstrating participation, indicating and correcting errors of performance. Our descriptions have captured the nature, underlying orientations and variety of both therapists' *and* patients' practices in a way that is not possible through categorising and counting conduct. We have also shown that it is possible to ground descriptions and explications of conduct in the data themselves, rather than imposing *a priori* categories and interpretations. Furthermore, the principle of 'ethnomethodological indifference' which we have followed – recognising that it is not for the analyst to endorse or condemn practice - has resulted in findings that are informative and constructive rather than condemnatory.

Through sequential analysis, we have been able to describe locations and circumstances in which different techniques and patterns of interaction recurrently arise, e.g. the way therapists' explanations of reasons underlying treatment tend to occur at starts or ends of treatments, or in circumstances of

therapeutic or interactional troubles. We have been able to describe the interactional functions and effects of the different techniques and patterns. For instance, we showed that embedded corrections of failures of performance can allow for rapid and 'smooth' management and for continuation of physical treatment activity; but on the other hand, that they do not provide opportunities for therapists to check patients' understandings about the problem and correction, or for patients to ask related questions. This example illustrates a more general point: that any interactional technique and pattern tends to have both advantageous and disadvantageous elements with respect to the process and requirements of physiotherapy and the implementation of recommendations. This is one of the reasons why it is not possible to generate simplistic, prescriptive conclusions stating which practices should or should not be used. Shortly, we will discuss this point further, and focus in detail on the sorts of conclusions and implications that this study *does* generate (Section 7.3). First however, we will revisit our earlier discussion of the relationship between practice and published recommendations by considering the insights of our findings for the generation, formulation and role of recommendations for good practice.

7.2.4.2 The generation and role of professional recommendations

Our analyses identified considerable discrepancies between the requirements of current published recommendations and the constraints associated with both clinical and everyday social interactions. These discrepancies raise questions about the relevance, appropriateness, and

usability of the recommendations. Any recommendations or standards will have certain inherent shortcomings. They are necessarily abstract and general because they attempt to encapsulate conduct that occurs across a multitude of settings and circumstances. They must to a considerable degree overlook the local construction of the meaning or sense of any interaction (Chapter 3, Section 3.3.2). For instance, whether participants are 'mutually participating' or 'fully involved', or whether 'relevant information' is provided, depends on and is constituted in participants' local there-and-then actions and responses. These are dependent on the unique circumstances of the particular interaction, and cannot be legislated for or encompassed by recommendations. Thus, it is not feasible or appropriate for them to precisely stipulate recommended practices and patterns of communication. However, what they *can do* is to lay out general guiding principles towards which therapists can aim in their communication practices on individual occasions.

A further characteristic of the recommendations (in common with professional recommendations in general) is that they necessarily apply only to therapists' practices, even though the interactive principles they aim at – mutual participation, dialogue, shared understanding and so on – are collaborative activities involving therapists *and* patients. Logically, even if therapists were able to comply with all their elements, this would not necessarily accomplish the recommendations' aims, because those depend on patients too.

A further element of the recommendations' emphasis upon therapists' contributions to interactions is their tendency, like some of the critical

commentaries to which we referred, to assume that a change towards patients speaking more, becoming more 'involved', could be brought about simply through therapists 'providing opportunities'. This assumption neglects the way that, as we have demonstrated, the asymmetrical pattern of interactions, including restrictions upon patients' talk and involvement, are produced through the actions of *both* participants, not imposed unilaterally by therapists. This assumption also neglects the complex origins and constitution of asymmetry, which relate to fundamental social orientations and conventions, held and acted upon by both patients and therapists. These conventions concern what forms of conduct are regarded as 'appropriate' for both clinicians and patients. Patterns of asymmetrical conduct maintain the differentials in clinicians' and patients' roles and activities that underlie the rationale of therapy. Put more simply, participation in physiotherapy only makes sense if the roles and activities of patients and therapists *are* asymmetrical, and are kept asymmetrical. Therefore, altering the symmetry of patterns of interaction is not simply a matter of giving patients more 'opportunities to speak'.

Nevertheless, therapists can, through certain practices, *facilitate* patients' involvement, whilst acting within and taking account of the constraints that operate. For instance, we observed that patients ask more questions and make more comments when therapists' physical guidance during activities is minimal or absent, compared to where activities are guided, or performed upon patients. This suggests that therapists can facilitate patients' questions and comments during 'hands off' exercises, or during breaks between

exercises. Further examples include specific techniques such as the 'perspective display' form of problem indication and correction, which can increase patients' involvement, and goal-setting practices wherein patients' views of their problems are sought.

The various shortcomings of recommendations described earlier in this section make for inevitable limitations in the direct applicability and specificity of their guidance. However, we would argue that current physiotherapy recommendations suffer further, specific shortcomings, and could be improved so that recommendations, although remaining abstract and limited to general principles and aims, could have greater precision and relevance to physiotherapy practice.

Current standards and recommendations (CSP, 2000; ACPIN, 1995) have been formulated on the basis of groups of clinicians, and sometimes patients, talking and thinking about practice. They are not grounded in empirical observational research into physiotherapy. This is perhaps inevitable given the current dearth of adequately detailed and rigorous observational research into physiotherapy interactions. CA studies have the potential to rectify this by providing better empirical grounding for recommendations. To give a simple example, this study found that during every session therapists recurrently engage in pointing out and correcting patients' failures of performance. It also found that, by various strategies, the relatively experienced therapists who were the participants of this study indicated and corrected problems in ways that did not bluntly criticise or distress patients,

and which could facilitate patients' understandings and involvement in therapeutic processes. Current recommendations do not address the fact that problem indication and correction are necessary and frequent elements of physiotherapy. However, they could do, and could lay out general principles for therapists to follow when doing so.

In summary, current recommendations underplay and fail to attend to the interactional constraints under which therapists and patients communicate, and they neglect the collaborative and complex nature of interaction.

Inevitably, any recommendations will be abstract, non-specific and directed only towards therapists' contributions to interactions. However, we have argued that recommendations more closely related to actual practices and circumstances of physiotherapy could be formulated, and that CA studies including this one could contribute to their formulation.

7.3 Scope and limitations of this study and its findings

Whilst advocating CA research and findings, it is important to discuss the limitations of this approach, as well as the nature and scope of the findings of this study, an issue we have already touched upon.

7.3.1 Nature and scope of findings

In physiotherapy, it can be relatively simple and appropriate for research to generate clear recommendations that particular physical clinical techniques should always be applied in particular circumstances. However, this is not

true of interactional practices, for which it is neither analytically feasible nor appropriate for studies to formulate simple recommendations and prescriptions. Unlike physical techniques, communication practices are not 'applied to' patients, they are collaboratively produced. In addition, interactional practices and their effects are highly variable depending on individual responses and circumstances. Also, judging whether an interactional practice is beneficial or effective is not so straightforward as for techniques with relatively simple outcomes and aims (such as increasing muscle strength or range of movement). As illustrated by our data, every interactional practice entails a variety of interactional functions and effects. These functions and effects are fluid and dynamic; they are a product of the local, individual circumstances of any interaction. Some effects may be perceived by clinicians and clients as advantageous and some disadvantageous. Furthermore, these perceptions tend to be variable and diverse. Thus, communication practices are too complex, and their meanings and effects too local and variable to allow simple prescription. Nevertheless, findings from studies such as this one are informative for practice, and have the potential to influence change in practice, as we discuss in Section 7.6.

7.3.2 Limitations of this study and its methodology

The highly focused, detailed nature of analysis using CA means that analyses are time-consuming and that any one study involves a relatively small database. Because of this, one study cannot hope to capture the whole range of interactive procedures that operate within a setting (Heritage,

1988b; Peräkylä, 1997). Also, because data concern naturally occurring events rather than experimentally induced or controlled ones, it can be difficult for a study to assess the impact of certain factors or to describe the full range of particular events. In this study for example, we only recorded one male therapist, and could not hope to capture any recurrent differences in interactions which involve male as opposed to female therapists. Another example concerns the small size of our collection of goal-setting sequences: although we could describe the *sorts* of challenges and practices that can arise therein, we could not propose a ‘typology’ of forms of goal-setting in the way we could for forms of indicating and correcting problems.

More broadly, this type of study does not claim to show what people are thinking (Silverman, 1997). We cannot, and do not aim to make claims about what patients and therapists might think or report about, for instance, whether a treatment session was successful or not, or whether they felt ‘involved’ or not. That is, CA studies do not focus on people’s perceptions of events, but on their actual conduct. They aim to restrict analytic claims to that which is observable in and through participants’ conduct. To illustrate what this means for the scope of this study’s analysis and findings, we revisit an incident, discussed in Chapter 3 (Section 3.8)⁵⁴, where a clinician observing a video-recorded sequence from the data reported that he viewed it as involving ‘bullying’ of the patient by the therapist. Because there was no explicit or implicit reference to bullying within the data itself, it was not

⁵⁴. This can be found in Extract S4Ph9PaUT1/2.55, Volume 2, p61-64, also examined in Chapter 5, Section 5.7.

possible to make any judgement about this based upon analysis. This example illustrated that such judgements are for participants and potential participants in therapeutic interactions (i.e. professionals and patients) to make. CA studies such as this one can inform these judgements.

Another limitation upon CA research is that certain aspects and forms of interactions can be difficult to research because of the reliance on recorded data. These include longer-term temporal processes (Peräkylä, 1997), events which occur across different locations and participants, and events for which one would be less likely to gain access and/or permission to record. One related limitation in this study was upon our data on goal-setting, a process that often involves many members of staff talking with the patient on many different occasions.

In Chapter 3 (Section 3.8), we discussed biases and limitations that might arise in this study because the researcher was also an experienced clinician. We acknowledged that this had the potential to skew data collection and to limit the scope of analysis. However, safeguards against these problems have been employed, and it is argued that the analyst's experience was beneficial for this study and its aims because of her knowledge of the setting studied, and of analytic topics that are germane to clinical practice and to questions raised in previous research.

The final set of limitations we will mention concerns the stroke rehabilitation setting in which we conducted the study, and the participants involved. In

this setting and amongst these participants, some circumstances that are frequent in other physiotherapy interactions did not arise. For example, very few instances in our data concerned patients' complaints of pain and therapists' management of these, and there were no data in which patients were treated in outpatient or domestic settings. We studied only interactions with patients who could speak and understand short sentences of English. Also, the therapists were all relatively experienced compared with juniors, students and assistants, whose interactive practices may therefore differ. Also, multiparty interactions were beyond the scope of our analyses. All these elements limit the circumstances and groups of people to which our findings might apply. This brings us to issues of generalisability.

7.4 *Generalisability of findings*

The study involved 11 therapists, 21 patients, and 74 recorded sessions. Thus, although a considerable volume of data was generated, this inevitably involved a small and selected group of participants and treatments. What then can we say about the significance of our findings and how these might relate to the conduct of other therapists and patients in stroke rehabilitation settings, and in other clinical settings altogether? That is, what can we claim about the generalisability of our findings?

Generalisability in qualitative research can be seen as having two aspects: empirical generalisability, which concerns whether specific descriptive findings are likely to be found in other settings; and a more theoretical or analytic level of generalisability (Hammersley, 1992; Murphy et al., 1998). A

key element of the latter concerns the role of qualitative research in developing concepts and theoretical frameworks which can form a basis for other investigations and analyses, and hence contribute to understandings about other settings. As we will discuss in Section 7.7.2, this study contributes to the conceptualisation of conduct with respect to the management of physical incompetence, as well as to issues of authority and of body movement as an interactional resource in clinical settings. It has done so by detailed examination of data in which these issues arise, and by reflection upon the relationship between these data, and findings and conceptualisations developed in other settings. Thus we argue that our findings have analytic generalisability.

We also argue that aspects of the patterns of conduct described here are likely to be found in (i.e. will be generalisable to) other settings – physiotherapy and beyond. We argue that this is likely because of three sets of reasons:

a) Features of these data, settings, and analytic foci are likely to be typical of physiotherapy settings in general

In Chapter 2 (Section 2.8), we argued that stroke rehabilitation was a useful setting for investigation because many physiotherapy activities that arise there commonly arise in other physiotherapy settings. These include the very activities upon which this study focused, e.g. instruction-giving, displaying participation and effort, managing errors of movement performance, and talking about reasons for treatment activities. Adding to

the likelihood that the patterns described in this study will be seen elsewhere, we focused our descriptions on the overall structural organisation of these activities, rather than their specific content. Also, the patients studied were typical of stroke patients undergoing acute rehabilitation for stroke in that they were treated in NHS hospital stroke unit settings. The therapists were typical of physiotherapists working in such settings in that they followed treatment approaches prevalent in the UK (see Chapter 3, Section 3.7.1). Additionally, recording data in four different hospitals meant that recorded interactions involved patients with a range of levels of disability and experience of physiotherapy, and therapists with a range of background experience and current workplaces. This increases the likelihood that findings are generalisable rather than idiosyncratic to a specific group of individuals. For these reasons, we argue that the conduct and orientations apparent here are likely to be seen across other physiotherapy settings, albeit with modifications and variations depending upon circumstances.

b) Features of our findings are consistent with patterns found in other, related settings, and are thus likely to be relatively generalisable

Throughout our analysis we drew upon research findings from related settings such as doctor patient interactions, in order to examine similarities and differences between patterns observed in this setting and in others. We found considerable areas of similarity: for instance regarding clinicians' use of perspective display sequences, and the circumstances in which they provide explanations for treatment actions. This consistency with other

findings makes it more likely that the patterns we observed arise in other clinical settings.

c) Orientations and constraints apparent in these recordings are likely to operate in other interactions

This claim to generalisability relies upon detailed explication of the orientations of the participants we studied and of the constraints upon their practices, and upon arguing that these orientations and constraints are likely to operate in related settings, and hence that similar practices are likely to occur therein. Our analyses showed that orientations to authority, to dealing with physical incompetence and its implications, and to various conventional social preferences and dispreferences were apparent in and shaped the therapists' and patients' conduct. We would expect these orientations to operate in other physiotherapy interactions, and thus argue that it is possible and indeed likely that the patterns of conduct observed in *these* patients and therapists occur in other physiotherapy interactions (*c.f.* Peräkylä, 1997, p215). These orientations can also be expected to operate to varying degrees in other related settings such as other therapeutic interactions (e.g. nursing, speech and language therapy), and other training interactions (e.g. sports, craft or musical training). Thus, as we noted towards the start of this section, the concepts and ideas developed in our analyses are likely to inform analyses of other settings, wherein they may be confirmed, amended or refuted (this is further discussed in the next section).

From this small and selected dataset, we cannot make definitive claims to have completely and precisely captured the range of practices that arise when therapists and patients communicate in the three domains examined. Further studies using differently selected data would be required to verify how and whether the patterns described here are manifest in other physiotherapy settings. This study has, however, generated a base upon which cumulative and comparative work could build.

7.5 *Future research directions suggested by the current study*

Continuing the topic of further studies, we will briefly outline some future directions suggested by this first contribution to CA knowledge of communication practices in physiotherapy.

One direction concerns further studies of physiotherapy interactions. Research could further investigate areas we have begun to explore within the current study, such as body movement and touch in physiotherapy communication, and goal-setting. Body movement and touch are undoubtedly difficult to research for several reasons. These include the paucity of current knowledge of their operation in 'ordinary' interactions, which could provide comparative data for any physiotherapy study; also the problems of analysing touch when only certain aspects of it can be discerned from video alone (e.g. it is difficult to discern qualitative aspects such as its forcefulness). Goal-setting research could include collection of data from specialist clinical settings that claim to particularly emphasise goal-setting. Another area that we touched on, but were unable to examine in depth,

concerned changes in interactional patterns between therapists and patients occurring over time, as patients become more experienced in and knowledgeable about physiotherapy.

This research has demonstrated that CA research is both feasible and productive in examining physiotherapy interactions. This suggests it would be fruitful to apply such analysis to forms and aspects of physiotherapy interaction that were not examined in the current study. These might include analysis of expert and/or novice practice, management of pain in physiotherapy interactions, analysis and comparison of interactions involving therapists working with different approaches (e.g. Movement Science and Bobath). Areas of communication which clinicians find particularly problematic may also form useful areas of study. For instance, during the course of this study, participant therapists identified communication with patients when more than one therapist is involved in the session as being particularly difficult, conversation analysis could be applied to investigate challenges arising in these multi-party interactions, and strategies that are used to manage them.

Beyond physiotherapy settings, and as suggested in the previous section, our analyses of the organisation of conduct and the orientations underlying it could inform study of other settings. For instance, investigations could examine whether similar patterns regarding indicating and repairing failures of performance are seen in training situations such as teaching a musical instrument, or sports training, and similarly whether similar 'student' conduct

regarding interactional participation and displays of effort are seen. In these settings, the 'student' is not normally suffering physical disabilities of pathological origin, differences that this contextual factor may make to conduct would be an interesting line of investigation.

Another future research direction would involve development of the findings of this study into training interventions for clinicians, and subsequent investigation into whether such training could effect measurable change (improvement) in communication practices. This might, for instance, involve increasing therapists' awareness and understandings about the various challenges that arise and strategies that can be used in dealing with shortcomings in patients' performances, or in dealing with the difficulties of goal-setting. Therapists' interactions with patients before and after such awareness training could be recorded and analysed to investigate whether conduct appeared to change.

7.6 Insights and implications for physiotherapy practice and research: conclusions

This study has shown that conversation analytic study of physiotherapist patient interaction can produce descriptions and explications of communication conduct at a level of constructive detail, empirical grounding, and explanatory power not achieved with other, more commonly used methodologies. We have argued that because of the methods and analytic foci of our study and the nature of the setting studied, the practices we

described are likely to occur in other physiotherapy settings. However, we have acknowledged that further cumulative and comparative work would be needed to verify this claim.

We must now consider what use the findings of this study and of further CA research in physiotherapy might be to professional practice. We have already proposed that findings could allow recommendations for good practice to be better grounded in knowledge of the basic tasks and contingencies of everyday physiotherapy practice. However, conversation analytic research and findings have other potential benefits with respect to improving practice and training.

Ten Have (1999) discusses the usability of CA findings, and draws on Heap's (1990) consideration of applied ethnomethodology, which stated that "[scientific] enquiry can deliver some of what we need to know in order to make reasoned judgements in particular situations about how to act to achieve some end" (in ten Have, 1999, p185). That is, it can help people make choices among courses of action. Our argument concerning how CA research could contribute to physiotherapy practice is closely related to this. CA research can deliver clear, specific and relevant descriptions and insights into communication practices – how physiotherapists and patients do certain things, and why they do them the way they do. It uncovers and explicates the circumstances, procedures, effects and functions of these practices. Because of this, it may help therapists make reasoned choices among possible courses of action. However, as suggested in the previous section,

further research is required to investigate how and whether it could actually do so.

Whilst Heap and ten Have argue that research can provide information needed for informed judgements, they do not propose that research studies or researchers themselves can *make* those judgements. In this vein, we have been careful not to make judgements as to whether certain practices are 'good' or 'bad'. Thus, although we examined the relationship between observed practice and the principles and stipulations of current published recommendations for good practice, we neither assumed nor argued that physiotherapy practice *should* measure up to those recommendations.

Thus, CA research can deliver information that is needed for reasoned judgements and choices about patterns of conduct in physiotherapy. It can provide information to therapists about how principles enshrined in recommendations may be translated into practice, but also allows reflection upon the recommendations themselves and exposes shortcomings in their practical feasibility and applicability. Decisions about what 'ends' are to be aimed at when choosing between courses of action must ultimately be for professionals and policy makers, not for the researcher to make.

In practical terms, CA provides analytic techniques and a vocabulary for analysing and reflecting upon communication conduct, and can provide specific information about how various communication challenges and tasks can be dealt with in physiotherapy. Therefore it opens up new directions for

the training of both student and qualified physiotherapists and for influencing practice improvement. Therapists could use CA's informative findings, techniques and vocabulary to:

- Develop reflective, evidence-based communication practice
- Reflect upon and learn from actual events where communication was problematic
- Analyse more specifically and objectively the practice of others such as students and juniors, and use this in training.

The implementation of findings into actual practice and training requires further investigation and evaluation.

7.7 Insights and contributions to ethnomethodological and conversation analytic research and knowledge

7.7.1 Contributions to methodology

A comparison of observed practice with the stipulations of published recommendations for good practice formed an important part of the methodology of this study. We argue that for several reasons, this is a particularly useful strategy for studies of professional-lay interactions which aim to generate practical and relevant findings for practitioners and policy makers.

We have already alluded to difficulties in generating and presenting practical insights and applications from CA studies. These arise from the complexity

of human communication and the difficulty of deciding what constitutes 'interactional effectiveness' (Maynard, 1991a: 50), as well as from the fact that no pre-established communication format or 'blanket strategy' (Maynard, 1991a) can be guaranteed to produce particular outcomes.

Nevertheless, we would argue, along with Maynard (1991a) that because conversation analytic investigations "deal with the real nature of talk" (p158), their findings can yield practical findings. The practical applicability of findings includes two elements. First, they can raise practitioners' awareness of the 'real nature' of communication, including its contingencies, complexity, and the underlying influences upon and orientations of people's conduct. Second, practical findings can inform practitioners (and indeed, patients) about how to perform certain interactional activities so as to maximise the potential for particular results (Maynard, 1991a) such as dialogue between practitioners and patients, or provision of explanatory talk with minimum disruption of physical treatment activities. In this section, we propose that the comparative methodological strategy we used is a valuable tool for generating such findings.

Several CA researchers have noted that CA analyses often do not seem to directly address the practical concerns of those it studies (see discussions in ten Have, 1999; Part iv, and within Maynard, 1991a, and Pilnick, 1999). In the case of clinical interactions, Pilnick (1999) has argued that CA analyses are relatively underdeveloped with respect to answering specific, practical questions about the management of various communication challenges

encountered, and the effects and effectiveness of various interactional practices. Beach (1995: 259), another CA researcher, has commented that issues which institutional members treat as significant are rarely directly compared with the findings of social scientists. We argue that the comparative approach used in this study can help to yield findings that contribute to answering such questions and concerns, and thus can generate practical findings from CA studies.

In broad terms, the methodological strategy we applied consisted of using CA to examine actual practices, and considering the relationship between these practices and certain normative proposals about clinical interactions. That is, we closely analysed actual conduct, and compared our findings with professional and policy ideas about 'how things should be'.

We argue that there are at least three ways in which such an approach is valuable:

1. Normative statements (in our study, published recommendations for good practice) can provide a point of common dialogue between analyst and practitioner. Practitioners and policy makers are unlikely to be familiar with the methods and technical language of CA studies, whilst they will have familiarity with professional recommendations. Thus, using recommendations as a comparator provides an accessible way of framing, focusing and presenting a study and its findings.
2. Recommendations form a set of proposals about how practice 'should be'; as such, they provide a principled route into the explication of

practices that are observed and described. This is because recommendations or normative statements form a backdrop against which to consider why people might act in the way they do, rather than in other (recommended) ways. One example is our analysis of communication about the reasons, purposes and goals of treatment activities (Chapter 6). The emphasis within professional recommendations on communicating with patients about these topics prompted a detailed explanatory analysis of reasons for its low frequency in this and other studies of physiotherapy interactions.

3. The approach enabled the study to articulate directly with professional concerns and clinical challenges, and thus to the generation of findings with direct practical and policy implications. For instance, we generated insights regarding the feasibility and relevance of current recommendations, and the possible scope and functions of recommendations in general. The study also generated findings that concerned practical professional questions about how certain communicative tasks within physiotherapy are achieved, and why certain activities do or do not occur (see the example in Point 2).

We should also acknowledge that this methodological strategy presents certain problems. Silverman (1997) considered the use of comparison between normative standards and actual observed practice for evaluating counselling. He argued (p23) that doing so presented various problems, including how terms used within these standards, such as 'congruence', 'empathy' and 'acceptance', could be 'differentiated' when applied to

observed sessions⁵⁵. Our approach differs from that which Silverman appears to be envisaging, in that we did not *evaluate practice against* normative standards and rate whether or not standards were complied with. Rather we explored the *relationship between standards and practice*, in order to both describe and explicate practice. However, this exploration, and also our discussion of the compatibility of specific practices with published recommendations (Chapter 4, Section 4.8; Chapter 5, Section 5.10; Chapter 6, Section 6.11), did present a difficulty related to the ‘differentiation’ problem Silverman voices. This concerned how to relate the *concrete practical activities* we observed to the *abstract terms and statements* of the recommendations: terms such as ‘full involvement’ and ‘mutual participation’. Since recommendations do not define these terms, anyone attempting to use them, including the analyst, must make some assumptions about their meaning. Thus, we assumed that ‘full involvement’ and ‘mutual participation’ would entail considerable interactional contributions by patients in terms of their comments, evaluations, questions, and communicative body movements, and specific attention to these by the therapist. Analysis then

⁵⁵. Drawing on work by McLeod (1994), Silverman asserts that two other problems arise in applying this approach. One concerns the choice of which portions and proportions of sessions should be evaluated – analysing small sections of sessions would lead to a gain in precision, but a loss of contextual understanding regarding practices. The other concerns the way that rating only the presence or absence of a particular ‘mode’ of practice (e.g. ‘empathy’) means that the skilfulness of the practice is not examined. These arguments are not so pertinent to the current study because analysis did not aim to rate sessions or practices in terms of whether practice represented or achieved normative standards or not (see main text).

entailed examining how and whether such features could be observed in the interactional patterns in the data.

Another challenge that arises when ‘using’ normative standards or recommendations in this way concerns how one can simultaneously maintain the principle of ‘ethnomethodological indifference’ (Chapter 3, Section, 3.2). To uphold that principle, both analyst and analysis must avoid endorsing (or implying endorsement of) the recommendations. In the current study, we did so by reflecting upon and expressing the practical implications of our findings in terms of how practices might contribute to the implementation of recommendations, *should practitioners wish to do so*. That is, analysis did not entail judgements about *whether* recommendations *should* be implemented. Furthermore, we critically analysed the recommendations themselves, rather than unquestioningly accepting them (see Section 7.2.4.2). In these ways, we were able to reconcile our analytic use of recommendations with the methodological principle of ‘ethnomethodological indifference’.

To elaborate our discussion of the utility (and challenges) of this form of comparative approach, we will examine two CA studies which used methodological strategies similar to that used here. First, Greatbatch and Dingwall’s study (1989) of interactional practices during divorce mediation. Noting that “advocates describe mediation as a process in which a neutral third party helps disputants reach their own agreements” (p152), they examine mediation sessions with respect to the notion of mediators’

neutrality. They found that “mediators frequently conduct themselves in ways that show that they are working with notions of favored and disfavored outcomes to the disputes” (p636), so that mediators’ “substantive neutrality” is called into question (p638). At the same time they stress that they are not proposing that this conduct is in fact “intrinsically unethical” (p638), instead they highlight the implications of their findings for issues of analysis and policy. That is, the researchers used normative proposals about neutrality in mediation practice as a stimulus to analysis, but did not align themselves to the ‘correctness’ of these proposals. This study thus highlights both the challenges and utility of using aspects of normative statements made about a professional practice to facilitate detailed analysis and generate policy-relevant findings.

Another study that used this form of comparison illustrates its potential for generating direct practical findings about professional communication and about professional policies regarding that communication. Beach (1995) examined doctors’ use of the term ‘Okay’ in consultations with patients in the light of normative pronouncements about what doctors ‘should’ do; specifically: a prescription made by one medical school that use of the word ‘Okay’ should be eliminated from medical interviewing. His detailed analyses of such interviews “reveal the indispensable utility of “Okays” for achieving diverse institutional tasks” (p282). Hence he argues that it is unrealistic to seek to eliminate ‘Okays’, and indeed, that doing so would be likely to considerably disrupt communication between doctors and patients. This study illustrates that both instructive insights and practically relevant findings

can be generated through comparing actual practice with professional pronouncements about how practice *should* be conducted. It also offers concrete illustration of an issue we have been highlighting in this discussion: simplistic prescriptions about communication practices are deeply flawed with respect to their validity and practical feasibility.

7.7.1.2 *Contribution to methodology: summary*

Our methodological approach, which involved examining the relationship between actual practice and normative proposals about good practice, has proved capable in this study and elsewhere of generating useful findings about professional practice. It can open up discussion of the feasibility, appropriateness, and overall role of normative proposals and recommendations. It also generates practice- and policy-relevant findings about why people communicate as they do, including why communication may not reflect professional recommendations.

7.7.2 Contributions to ethnomethodological and conversation analytic knowledge

This study has contributed to knowledge about the organisation of interactional conduct in therapeutic interactions and the orientations that underlie it. Here we highlight findings that, we argue, constitute new contributions to this knowledge. These concern three areas:

- Observations about how body movement and touch function as a resource for dealing with delicate matters and conveying the nature of embodied activities.

- Contributions to knowledge in the well-researched field of professional authority and how it is constituted and manifested in therapeutic interactions.
- We would propose that the greatest contribution of our study is to describing and explicating how the management of physical incompetence by both patients and clinicians influences their conduct. Specifically, that across many aspects of conduct in therapeutic interactions, participants can be seen to orient to limiting or countering the implications that arise when physical incompetence is exposed and attended to.

7.7.2.1 *Body movements in clinical interactions*

Although our observations and findings about body movement in physiotherapy interactions were preliminary ones, we propose that these nevertheless contribute to the growing body of conversation analytic findings about how body movements function, particularly within institutional interactions. We showed that body movements including touch, gesture, and physical demonstration are used alongside talk to develop mutual understandings about the embodied activities that are proposed and performed during treatment. We suggested that physical demonstration is particularly useful for communicating about complex or novel physical activities. Also, that compared to talk, gesture and touch, demonstrations can represent an ‘upgraded’, more powerful resource: used when understandings about physical activities are proving difficult to achieve (see analysis of S2Ph3PaHT3/11.58 in Chapter 4).

Our other main observation about interactional body movements concerned their role in performing potentially delicate actions. In Chapters 4 and 5 we examined extracts that illustrated how therapists use body movements, including touch, to indicate and correct patients' failures of performance. We noted that this is a potentially delicate activity because of general constraints on co-participant criticism, because it is potentially distressing and demotivating, and because of the problematic implications which can arise when patients' incompetence is exposed. We observed that one of the strategies therapists regularly employ to deal with patients' failures of performance is to repair the problem without bringing it to the (verbal) interactional surface. Body movements form an integral part of this strategy (e.g. S2Ph3PaHT3/11.58 in Chapter 4).

Likewise, we observed that body movements are used by *patients* to perform certain potentially delicate activities. These particularly concerned actions that might interrupt therapists' talk and actions and/or question their authority and expertise. In our data, patients recurrently use body movements to indicate to therapists the level and quality of their participation in treatment activities. We noted that body movements are an especially important resource for patients to convey their efforts during guided movements - in which they cannot convey their participation through initiation of independent movements (Chapter 4). We also observed that patients use such things as glances, head shakes or facial expressions (S1Ph1PaBT2/11.08, S4Ph10PaRT3/10.24 in Chapter 4, S3Ph5PaNT2/2.25 in Chapter 6) to seek

information from, or prompt action by, therapists. These body movements provide patients with an alternative to direct questions or other interventions that might disrupt a therapist's activities or imply questioning of their authority.

7.7.2.2 Variations in patients' interactional involvement depending on therapists' physical contribution to activities

The second area of contribution our findings make to knowledge about the organisation of therapeutic interactions concerns the relationship between professional authority and the asymmetry of professional patient interactions (discussed at length elsewhere, particularly Chapter 4, Section 4.5). Both in this study and in previous ones, it has been found that patients constrain their interactional contributions in ways which constitute and maintain the clinician's authority; also that the degree of asymmetry and of patients' interactional contributions varies in extent within and between encounters.

Our study has shed light on one of the factors that contributes to such variations: the degree of the clinician's physical guidance. We showed that in our data, the greater the clinician's physical contribution to a treatment activity, the less the patient tended to talk, whether commenting upon the activity or asking related questions. During physiotherapy, the therapist's physical contributions are greatest during physical examinations and treatments performed upon patients' bodies or body parts (e.g. 'mobilisations'). We observed that during these forms of activity, patients tended not to make comments or ask questions about the activities

themselves; also that they did not self-initiate body movements as part of those activities, nor as indications of their effortful participation in them (findings consistent with other studies, e.g. Heath, 1986, Chapter 5). We observed that patients made greater physical contributions to treatment activities in which movements were physically guided by therapists. During these, patients can be seen to make 'effort displays' which convey their active participation, however, we noted that patients did not initiate comments or questions about performance during these activities. We argued that to do so would potentially comment on and question the therapist's performance too, and was thus avoided because of patients' orientation to upholding therapists' expertise and authority. During physiotherapeutic activities which patients performed under verbal but not physical guidance, we showed that patients regularly ask questions and seek further information from therapists about the activities, and sometimes produce evaluations of their own performance. We argued that the greater need for verbal information in the absence of tactile guidance could be one factor explaining the presence of patients' comments and questions, but that a further factor was that these comments and questions did not carry the potentially authority-questioning implications of comments during guided activities.

In summary, our findings showed that, because of how orientations to authority shape and constrain patients' interactional contributions, their contributions tend to be greatest when therapists' 'hands are off'. Thus, the degree of clinicians' physical contribution to the ongoing activity constitutes a

source of variation in the asymmetry of clinical interactions with respect to the level of patients' interactional contributions.

7.7.2.3 Management of competence and incompetence as an influence upon conduct in clinical interactions

The third area of knowledge to which our study contributes concerns how the management of 'competence issues' pervades conduct of both clinicians and patients throughout their interactions. These 'issues' concern the implications that tend to be associated with episodes of physical incompetence: first, that the physical failure was wilful, that it was intentional or at least reflected a lack of effort and control on the part of the person; second, that physical failure reflects - is indicative of - incompetence of a greater scope, and particularly that it extends to cognitive, 'personal' incompetence. Our summary of the study's findings (Section 7.2.1) showed that many and various aspects of therapists' and patients' conduct attend either to avoiding exposure of physical incompetence, or to countering and limiting its implications if it is exposed. For instance, when analysing interactions concerning the nature of treatment activities and of participation, we saw how therapists' instructions may be 'sensitively designed' so as to avoid or minimise exposure of incompetence and allow emphasis on areas of competence and achievement. We saw how patients' practices, including their co-operative responses and 'effort displays' countered implications of wilful incompetence and conveyed competence in recognising and working towards alleviating shortcomings. When analysing interactions concerning success or failure of performances, management of 'competence issues' was

especially apparent. Therapists often avoided drawing attention to patients' physical shortcomings, and through a variety of management strategies they countered implications that the patient was wilfully incompetent, and emphasised areas of competence and potential achievement despite current failures. Through various practices, patients attended to showing their competence in recognising failures and in co-operating with efforts to correct them; they also attended to showing that failures were 'genuine', and did not constitute wilful lack of effort.

The orientation to limiting exposure of patients' physical incompetence seemed on occasion to result in conduct that gave rise to local interactional difficulties. For instance, at times, this orientation seemed to result in oblique and ambiguous communication by therapists which was associated with patients displaying distress and failure to understand. Another apparent difficulty was therapists' reluctance to discuss certain issues with patients, even where patients made efforts to raise them. In the clearest example in these data, a patient repeatedly made comments about his affected hand and arm that seemed designed to elicit dialogue with the therapist, but the therapist avoided all but the most innocuous comment and rapidly changed topic (S2Ph4PaMT1/1.37 & 1.40 in Chapter 5).

We also saw that this orientation could present difficulties with regard to explanatory and goal-setting talk. We proposed that it is at least part of the reason why there is a tendency not to introduce explanatory and goals talk during physiotherapy interactions. Additionally, we argued that attempting to

avoiding exposing 'wider' incompetence is a factor which underlies patients' reluctance to contribute to interactions by self-evaluating their own abilities and performance, and by asking direct questions of therapists.

Therefore, not only have we illustrated the ways that this competence orientation shapes conduct, we have also shown how it lies at the heart of certain fairly common complaints and criticisms of therapeutic communication. These include arguments that patients' involvement in treatment actions, decisions and dialogue is less than it should be, and that therapists do not explain or talk about certain things that patients would like them to. Previous analyses (e.g. Pilnick, 1998; ten Have, 1991; Maynard, 1991b) have concentrated on how orientations to authority and asymmetry contribute to conduct which prompts such criticisms and complaints. Our analysis has illustrated that orientations to avoiding exposing patients' incompetence and limiting its implications also contribute.

In the physiotherapy setting these orientations are especially apparent for several reasons. These include the focus of clinical attention upon basic physical competencies, and the way that patients' performance of treatment activities go on 'under the eye' of the clinician (see Chapter 1, Section 1.3). Therefore in physiotherapy interaction, physical incompetence is especially likely to be repeatedly exposed and attended to. However, we would nevertheless propose that in any interaction where aspects of one participant's physical incompetence are likely to be exposed, and hence where implications of wilful failure or wider incompetence are likely to arise,

patterns of conduct that bear resemblance to those we have described are likely to occur. Thus, our findings may offer insights for future conversation analytic research into other clinical interactions, and into encounters such as those where sporting or musical skills are coached.

7.8 Conclusion

This ethnomethodological, conversation analytic study of interactions between stroke patients and physiotherapists during treatment sessions has contributed to knowledge in both physiotherapy and sociology. It has demonstrated that detailed conversation analytic research into clinical practice can produce rigorous findings about how therapists and patients achieve the interactional tasks of physiotherapy, which have relevance to practice and policy. The interactional tasks we focused upon were:

- Giving and responding to instructions about physical treatment activities
- Producing, soliciting and responding to evaluations about the performance of those activities
- Communicating about the reasons, purposes and goals of treatment activities

The study generated detailed descriptions of various patterns of patients' and therapists' interactional conduct within these three areas, and developed explications about their interactional functions and effects. We argued that using findings to generate 'blanket prescriptions' about 'good' and 'bad' clinical interactional practices is not appropriate because of the complex, multifaceted, and locally-constructed nature of human interactions.

Nevertheless, we proposed that in practical terms, findings could enhance practitioners' understanding of the contingencies and underlying orientations that shape communication conduct, and could raise their reflexive awareness of the effects of different approaches to achieving various interactional tasks. We proposed that such improved understanding and awareness could

facilitate improvements in clinical communication practices and in clinical training in these practices, but acknowledged that these assertions would need testing via further research investigations.

A comparison between observed practices and current published professional recommendations showed how some aspects of the practice we observed conflicted with these recommendations, whilst other aspects conformed with them. This comparison stimulated our analysis of why patients and physiotherapists act in the ways they do, and raised questions about the feasibility and relevance of current professional recommendations and of recommendations in general.

Our study also contributed to ethnomethodological and conversation analytic bodies of knowledge with regard to methodological strategies for researching professional communication and to the organisation of conduct in clinical professional interactions. In terms of the former, we suggested that the strategy of comparing normative proposals about professional practice with actual observed conduct offers a valuable means of producing practice-relevant findings. In terms of the latter, a particular contribution has been made to understandings of how people's orientations to physical incompetence, specifically, to avoiding its exposure and countering its implications, pervade and shape their conduct during clinical encounters.

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