Doctor-patient interactions during medical consultations about obesity

Volume 1: Thesis

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Abstract

The current "obesity epidemic" is a global concern for governments and healthcare organisations. Obesity is seen as a medical problem of excess body weight which can be resolved through interventions to encourage weight loss, most particularly diet and exercise regimes. Much existing sociological work focuses on moral understandings of obesity as a perceived symbol of individual greed and laziness in a culture that prioritises self-control and effort. This neglects the ways in which the condition is actively discussed and managed in relevant settings such as medical encounters. This thesis addresses this research gap by analysing talk during obesity-related medical consultations. Talk is central to all medical encounters and has particular resonance in treatments for obesity where most interventions are carried out by the patient away from the medical gaze. Patients must report on their treatment behaviours in ways that enable practitioners to evaluate them and offer further relevant advice. Talk is not only a means through which treatment is delivered but a form of treatment itself.

Fieldwork took place in two UK NHS outpatient clinics specialising in weight loss treatment for obese patients. A sample of 18 patients and 1 doctor consented to have their consultations video-recorded over a period of 9 months. This resulted in 39 recorded interactions which were analysed according to the principles of Conversation Analysis (CA) to identify recurring patterns of interaction. The thesis describes how talk between doctor and patient functions to achieve certain tasks. In particular, it analyses how the specific institutional setting shapes and is shaped by talk. A dominant theme is that clinic interactions

frequently invoke normative issues concerning knowledge, responsibility and effort. These issues are consistent with moral dynamics perceived to surround the condition of obesity and patient responsibilities. Doctor and patient collaboratively construct obesity as a moral issue. This has consequences for the conduct of the consultation. The findings extend existing CA knowledge on medical interactions and demonstrate the utility of an interactional approach to the sociological study of obesity. They also have relevance to healthcare policy and practice.

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Thesis Introduction

"These days, 'modern life' can mean we are a lot less active. With so many opportunities to watch TV or play computer games, and with so much convenience and fast food available, we don't move about as much or eat as well as we used to. This can cause life-threatening diseases like cancer, diabetes and heart disease- so it's really important that we do something about it…We all know it can be hard these days to live a happy, healthy life …After all, none of us are perfect…Even the best of us can make small changes." (nhs.uk/change4life, 2009)

In January 2009 the UK government launched 'Change4Life', the latest in a series of initiatives to promote healthier living – specifically healthier eating and exercise – in the child and adult population. This, and other such campaigns, was founded on concerns over perceived high rates of obesity in the UK. As a medical condition, obesity refers to an 'unhealthy' excess of body weight and is associated with a range of other medical problems. Medical treatments for obesity encourage the individual to lose weight under the supervision of a healthcare practitioner. Although surgery and pharmaceuticals may be available, all interventions begin with diet and exercise programmes that attempt to reverse the overeating and under-exercising assumed to have caused the onset of obesity. These behavioural interventions position much treatment control with patients, since they are carried out in their own time and under their own management, away from the medical gaze. Obesity is therefore a 'lifestyle' condition with a 'lifestyle' cure. Normative assumptions and judgements about individuals' lifestyles -

for example in references to eating "well", being "happy and healthy" and not being "perfect" – are visible in obesity policy. Are they also visible in obesity-related medical consultations?

This thesis concerns doctor-patient interactions in medical consultations about obesity. It considers how the condition and its management are discussed and how this talk may shape and be shaped by the medical setting in which it occurs. I begin (chapter 1) by discussing how existing medical, scientific, government and interest group literatures construct obesity as a social problem in need of change. I show that a dominant construction positions obesity as a medical problem threatening the health of individuals (and the financial health of the state), necessitating professional intervention. This is challenged by a 'moral model' which constructs obesity as a personal failing caused by laziness and greed and a 'political model' which argues for individuals' rights to physical largeness. I also discuss current UK policy on obesity and show its relationship to two central themes in the thesis. The first is that obesity management intertwines medical and moral concerns by providing the patient with medical attention but simultaneously demanding that he/she take some responsibility for his/her condition and its cure. The second theme is that talk is crucial to consultations about obesity since patients are required to report on their treatment behaviours and efforts in ways that enable the practitioner to evaluate them and produce further relevant advice. Talk is a medium for treatment and a form of treatment in itself. It therefore demands analytic attention.

In chapter 2, I review existing social scientific literature to discuss the extent to which it provides insights into talk during obesity-related

medicine. I show that whilst much research attempts to describe how social factors might influence which individuals become labelled obese and the attitudes they may hold about it, insufficient attention has been paid to what happens when those individuals receive medical treatment for their condition. Drawing on key studies from the sociology of medical interactions (plus the sociology of food and the sociology of the body), I argue that talk between practitioners and patients is central to the conduct and outcome of medical encounters and that the achievement of medical tasks through talk can involve references to 'sensitive', 'moral' issues, particularly when lifestyle conditions such as obesity are being discussed.

Chapters 3 and 4 outline the methodology and methods of the thesis. In chapter 3, I present Conversation Analysis (CA) as the appropriate interactional approach for the study. I discuss its theoretical underpinnings and status as a naturalistic, observational form of social enquiry that provides the analytic tools and procedures necessary to investigate talk in various settings, including institutional ones. In the methods chapter (chapter 4), I describe the design and conduct of my fieldwork and analysis. Fieldwork took place in two NHS outpatient clinics specialising in providing weight loss guidance to obese patients. Over a period of 9 months, I video recorded consultations between one doctor and a sample of 18 patients. The chapter includes descriptions of how I set out about transcribing and analysing the data from these consultations and also provides relevant ethnographic details about typical activities in the clinics.

The four data chapters describe how particular medical tasks are achieved through interaction. A recurring theme is that the talk which

accomplishes these tasks also performs other actions – in particular 'moral work' invoking issues of knowledge, responsibility and effort in relation to obesity and its medical management. This is seen in chapter 5, on opening questions and responses in the consultation. I show that when answering the doctor's opening questions, patients not only provide information relevant to the start of the encounter, they also invoke normative issues in ways that justify and defend their status. In their answers, patients can be heard to imply issues of success and lack of success in weight loss. Whilst producing these answers, patients consistently display knowledge of their condition and indicate they are making an effort to become well, whilst enhancing their agency in relation to successes but avoiding responsibility for any lack of progress. They present themselves as 'good' patients who deserve medical attention and who are prepared to make an effort to become well.

Chapter 6 details my interest in analysing compliments. Government guidelines recommend the frequent praising of patients in order to encourage them in their weight loss efforts but I show that this is a complex activity to achieve and even identify in interactional terms. My analysis indicates that when the doctor produces crediting turns, patients tend to respond in ways minimise self-praise. However, they also assert their ability to know about and assess their own condition. I argue that policy guidelines should recognise the complexity involved in conversation and I raise methodological questions about how CA can identify particular interactional forms.

In chapter 7, I turn to the treatment/advice-giving phase of the consultation. I analyse sequences in which the doctor solicits the

patient's opinion on how treatment should proceed before delivering his own view. I describe how these discussions can unfold in very different ways and show that, whilst soliciting the patient's view treats that view as medically relevant and can provide opportunities for alignment, it can also make disagreements more visible and lead to tensions in the interaction. My analysis reveals that this kind of interactional device, common to ordinary talk and observed in other medical CA studies, can have particular functions and consequences when occurring at the start of treatment/advice-giving phase in medical encounters.

The final data chapter (chapter 8) concerns closing sequences. Existing CA literature indicates that practitioners use a variety of devices to initiate the end of consultations and that the accomplishment of these sequences may be delayed if the practitioner has not been able to demonstrate the provision of a specific, tangible solution to the patient's medical problem. The status of obesity as a long-term, chronic condition, plus a variety of institutional constraints, suggested that tangible, specific treatment solutions were rarely possible in the fieldwork clinics. My analysis shows that, despite these possible barriers, closings in the clinics generally occur over a small number of turns and with co-alignment between participants. They also occur through a wider range of actions than observed in previous studies, with non-vocal actions playing a key role. I show that the actions employed to initiate closings in my data can be connected to the particular features of the setting, including the few instances of 'trouble'.

These data chapters present empirical findings that make unique analytic contributions to conversation analysis, sociology and

healthcare policy and practice. In my final discussion, at the end of this thesis, I summarise my findings and describe how they contribute to these different areas. I argue that, in the first instance, my research adds to CA knowledge of the interactional procedures that accomplish talk, particularly demonstrating the value of analysing medical talk in secondary care settings. I also show how my work opens up a new, interactional, direction for sociological research into obesity. Finally, I argue that healthcare practitioners and policy makers would benefit from treatment guidelines based on empirical, rather than abstract, understandings of practices of talk in the consultation.

In the final part of the discussion, I propose the need for further interactional research into medical consultations about obesity. I argue that future projects can maximise the findings of this thesis and make an increased analytic and practical contribution. 'Experts' suggest that the modern obesity 'crisis' is set to continue and that increasing numbers of people will become obese (since, "after all, none of us are perfect"). If more and more of us will need to discuss our weight and weight loss with our doctors, it is crucial to identify barriers to communication that may arise in these consultations, plus the means through which they may be overcome.

Chapter 1: The construction of obesity as a social problem

1.1: Introduction

"Obesity occurs when a person puts on weight to the point that it seriously endangers health. Some people are more susceptible to weight gain for genetic reasons, but the fundamental cause of obesity is consuming more calories than expended in daily life." (National Audit Office, 2001: p. 1)

In February 2001 the National Audit Office published "Tackling obesity in England". This report uses population data to argue that obesity is a significant medical problem in need of government intervention. Northrop (2005) describes this report as a "trigger event" (p. 2) in moves to position obesity as a primary health risk in the UK; indeed the past 8 years have seen increased medical research and policy discussion about the condition and its treatment. At the same time, other interested groups including researchers, activists, commercial organisations and lay organisations have published their own reports into obesity, often challenging 'official' views on how problematic it is and what consequences it has for individuals and society. In this chapter I review these different literatures, focusing on UK material. I adopt a constructionist approach to discuss how different groups attempt to position obesity as a social problem in need of change. This discussion reveals that the literatures are characterised by disagreement, especially in competing medical, moral and political 'models' which can be seen to alternately position obesity as a health condition, a symbol of individual failing and a problem of discrimination.

In the final part of the chapter I outline current UK policy and guidance on obesity. This sets up a number of themes of interest to my study. In particular, UK policy treats obesity as a medical problem and describes talk between practitioners and obese patients as central to the delivery of its treatment. In combination with the wider literatures, current treatment guidance suggests a number of tensions that may occur in this talk, not least because recommended treatment practices can be seen to invoke moral as well as medical concerns. Consequently, this chapter establishes a role for sociological investigation of talk during obesity-related medicine.

1.2: Obesity as a social problem

"In our social lives, we tend to use the term social problem to categorise conditions that we believe are troublesome, prevalent, can be changed and should be changed." (Loseke, 2003: p. 7)

The sociology of social problems can be conducted with reference to various theoretical approaches. One of these is the functionalist approach, which dominated sociology from the 1920s to 1970s. Functionalism defines society as a homeostatic system, dependent on shared beliefs and norms for the maintenance of its equilibrium. According to Merton, a key writer in this tradition, a social problem is "a substantial discrepancy between widely shared social standards and actual conditions of social life." (Merton, 1971: p. 799). Social problems may take the form of deviant behaviour or societal disorganisation but are always created by objective conditions. Functionalism's emphasis on objective phenomena enables the sociologist to measure the

problem but provides no means to assess individuals' subjective interpretations of it. So a functionalist approach would deal with the 'objective' official/medical definitions of obesity but would not consider whether these are universally accepted.

From the late 1930s onwards the functionalist approach was challenged by value conflict theory, which states that social problems are defined via subjective value judgements. The role of the sociologist is to describe 'the attitude' (Waller, 1936) that constitutes a phenomenon as a problem rather than its 'objective' state. Attitudes are comprised of value judgments about organisational and humanitarian mores. Inevitably, agents describe the same societal conditions in different ways because they do not share the same fundamental values. This leads to disagreement on how problems should be solved at an organisational level. Social problems exist because of this conflict. Unlike functionalist perspectives, the value conflict approach acknowledges the importance of subjectivity and diversity in the establishment of social problems. However, it tends to describe conflict as static and does not provide a framework to analyse the context in which arguments arise. It lacks a temporal element and is therefore unable to conceptualise how certain issues become seen as social problems at particular times.

The constructionist approach provides a temporal dimension to the understanding of social problems. Originating in the 1970s in the work of Spector and Kitsuse (1977), it describes social problems in terms of activities rather than static conditions or attitudes. Like value conflict theory, the constructionist approach emphasises the existence of subjective definitions but also states that social problems are

constituted of "the activities of individuals or groups making assertions of grievances and claims with respect to some putative conditions." (p. 75). Within this perspective, the sociology of social problems should be concerned with the activities of relevant individuals and groups rather than the status of the 'problem' itself. It is not necessary to verify whether conditions are objectively 'real' since the focus of analysis is on how perceived conditions are constructed as problematic. Although the constructionist approach does not deny that 'real' conditions do exist, its emphasis on how they are constructed leaves questions over how those conditions can be analysed further (Latour, 2004). Furthermore, it can be vulnerable to charges of 'ontological gerrymandering' (Woolgar and Pawluch, 1985) in which the analyst argues it is not possible to know the social world but nonetheless goes on to make claims about it. Despite these reservations, the constructionist approach is used here to discuss obesity as a social problem in the UK. It is preferred to the other approaches discussed above as its emphasis on process provides a framework and vocabulary to understand the competing dynamics at work in the framing of the condition.

The constructionist approach to the sociology of social problems has a number of philosophical roots. It draws on Durkheim's (1938) argument that humans create their own culture and ethnomethodology's (Garfinkel, 1967) interest in studying how actors create and sustain 'reality' through their own actions. It also takes up phenomenology's position that agents imbue social life with meaning and react to the world through those meanings (Schutz, 1962). Since the world is too complex for us as individuals to experience in its entirety, we construct 'typifications' - models of typical people and things which aid our understanding of the world (see also chapter 3).

Since we do not experience all social problems conditions first-hand, we also construct typifications of those conditions. These typifications are central to social problem activities, are subjective and are prone to fragmentation and conflict. Social problems are therefore always products of disagreement (Maurer and Sobal, 1995). The activities constituting the problems take various forms and are called social problems 'work'. As the above quotation indicates, this work sets out to establish that a problem exists, is prevalent, is negative and in need of change, and can be changed. Key components of this work are claims, claims-makers and audiences. A claim is "any verbal, visual or behavioural statement that tries to convince audiences to take a condition seriously." (Loseke, 1999, p. 27). Claims are put forward by claims-makers. These are any interested individuals or groups, including governments, scientific communities, commercial organisations, and activists. Audiences listen to and evaluate claims and consist of whoever is perceived as interested or influential to the specific situation. Because social problems construct what is 'wrong' in a society, claims always convey moral arguments. The fragmentary nature of typifications means that social problems work is always competitive. Claims-makers must compete for audience attention against rivals sharing different views of the same condition, as well as those working on other conditions. Furthermore, claims-makers do not begin as equals. Even though audiences differ, there tends to be a hierarchy of credibility in which certain claims-makers – such as mainstream scientists – are perceived as automatically more believable than others.

The constructionist approach provides a fruitful way to discuss obesity as a social problem. It does not suggest that obesity does not exist as a

biological condition or that there is no need to be concerned about it. However, it does indicate that the ways obesity is talked about, understood and acted on are products of a specific space and time as well as the vested interests of particular groups. In the following sections I discuss social problems work about obesity. I show how various claims-makers work to construct obesity as a social problem and compete to describe it as a medical, moral or political issue. The modelling of obesity in these different ways has particular consequences for how it is seen to be undesirable and how proposals to change it are made.

1.2.1: Showing the condition exists

"The primary way in which new ideas or diseases achieve legitimacy or recognition in modern society is for scientists or physicians to call them "real"." (Figert, 2003: p. 128)

Establishing the 'existence' of a condition is the first part of social problems work. Medical (and government) claims that obesity exists are made through the adoption of a calculation that both defines and measures obesity in individuals. Although different medical definitions exist (Wellcome Trust, 2005), the Body Mass Index (BMI) has emerged as the dominant one, adopted in medical texts, prevalence statistics, and policy documents (Sandowski, 2000). The BMI was developed in the late 19th century (Sandowski, 2000; Hacking 2007) and is a calculation of an individual's weight in kilograms divided by height in metres squared (kg/m^2). The resulting number functions to estimate the distribution of fat in the individual's body and can be compared to a series of categories set by the World Health Organisation (World Health

Organisation Expert Committee, 1995) to classify how 'healthy' the individual is. A BMI of 18 – 24.9 indicates 'normal' or 'healthy' weight and 25 – 29.9 indicates overweight. Anything over 30 is described as obese and over 40 as morbidly obese.

Within the medical profession there is also recognition that the BMI has limitations. BMI cannot be used to calculate obesity in children (as their heights are unstable) and may be unreliable for certain ethnic minority groups, the very old and the very fit (Cole, Bellizzi, Flegel, and Dietez, 2000; Sandowski, 2000; Haslam, 2005; World Health Organistion, 2006). For example, the average athlete is likely to have highly developed muscles and, since muscle weighs more than fat, will therefore be likely to have an 'obese' BMI status of 30 or more, even though his/her weight presents no health complications. Recognition of these limitations has led to calls for a more sophisticated approach to identifying obesity in individuals (e.g., Haslam, 2005). Additionally, NHS treatment guidelines (National Institute for Health and Clinical Excellence, 2006) now state that other obesity definitions – such as waist circumference measures – can usefully complement BMI, whilst also recommending different BMI categories to apply to ethnic minority patients. Nevertheless, the BMI on its own can still be seen as the 'gold standard' definition and is the means through which population statistics are generated (see below). The constructionist approach to social problems emphasises that scientific and medical professions have particular authority to state that a condition exists. Writing about the USA, Sobal (1995) directly connects this authority to defining obesity, stating that "medical people and their allies made increasingly frequent, powerful and persuasive claims that they should exercise social control over fatness in contemporary society" (p 69). Sobal notes that the use

of measurement and quantification have played a key role in this medicalisation; this can be seen in the use of statistics establishing prevalence, as discussed below.

The medical definition of obesity transforms excess bodyweight from a visual category into an 'objectively' measured one (Jutel, 2006). However, this definition and measurement are not universally accepted. For example, pro-fat/anti-diet researchers and activists (e.g., Campos, 2004; LeBesco, 2004) often challenge the medicalistion of excess bodyweight and use terms such as 'fat' and 'fatness' in resistance to it.

1.2.2: The condition is widespread

"In England the proportion of men classed as obese increased from 13.2% in 1993 to 23.1% in 2005 and from 16.4% to 24.8% for women during the same period of time." (The NHS Information Centre, 2007: p. iii)

A social problem must be understood to be prevalent in a society. It is not enough for audiences to have anecdotal experience of a condition; they must be convinced that it exists beyond their immediate surroundings. A series of reports published by the UK government works to convince audiences, comprised of the medical profession, health interest groups and the general public, that obesity is prevalent. These include the 2001 National Audit Office report mentioned above, the 2003 Health survey for England (Sproston and Primatesta, 2003; Wardle, 2003), The 2003 Scottish health survey (Scottish Executive, 2005) the Department of Health (2004a) "Summary of intelligence on

obesity", and the NHS "Statistics on obesity, physical activity and diet: England 2006". (The NHS Information Centre, 2008). These various studies use BMI calculations and statistical methods to argue that obesity is widespread and increasing in incidence. They also indicate that distribution is uneven, with individuals in lower socio-economic groups and from black-Caribbean and Pakistani communities more likely to become obese. In addition the government's science think-tank, Foresight (2007) extrapolates current trends to predict that if rates remain the same, 60% of men, 50% of women and 25% of children will be obese by 2050.

In producing these reports the government can be seen to employ strategies noted by Loseke (2003) as characteristic of social problems work: constructing simplicity and anticipating themes likely to appeal to audiences. This is achieved in a number of ways. Firstly, the use of quantification enables the production of simple, memorable messages. This is aided by the promotion of BMI as a measurement for entire adult populations without mention of its limitations. Another means of constructing simplicity is to merge statistics on obesity with the related but less 'serious' condition of overweight. This merging then produces a single, higher figure. For example, the 2004 "Summary of intelligence on obesity", mentioned above, is designed to report on obesity alone but states that "[t]he prevalence of obesity has trebled since the 1980s, and well over half of all adults are either overweight or obese" (Department of Health, 2004a: p. 1).

These reports also adopt themes likely to appeal to audiences. They often emphasise the existing and growing prevalence of obesity in children, an emotive theme likely to appeal to a significant proportion

of the population. These reports can also be seen to generate interest by linking current prevalence to sudden increases and making predictions of further rises, thereby stressing that obesity is a growing phenomenon. Finally, comments such as "[t]he growth of obesity in England reflects a world-wide trend" (National Audit Office, 2001: p. 1) and references to World Health Organisation publications on a global epidemic (e.g., World Health Organisation, 2000 and 2006) draw attention to obesity as a worldwide condition and underscore the extent of its prevalence.

These descriptions of prevalence do not go unchallenged. Counter-claims state that obesity's prevalence has been exaggerated due to the use of BMI and the (mis)use of survey data. A report by the Social Issues Research Centre (2005) re-analyses data from the 2003 "Health survey for England" and concludes that whilst obesity is a cause for concern, "the extent of the problem …[is] often subject to hype and exaggeration." (p. 2). By investigating age groups separately, the authors argue that the data show increases in prevalence amongst the middle-aged but decreases in some younger age groups. They also criticise the government for adopting a "pessimistic" (p. 5) procedure for measuring obesity in children and argue that the use of the International Obesity Taskforce's alternative measurement methods (see Cole, Bellizzi, Flegel, and Dietez, 2000) would show more modest increases in prevalence.

In an exhaustive review of the scientific literature on obesity, Gard and Wright (2005) also question the use of survey data. They argue that epidemiological data are routinely misread, allowing claims that obesity has become an 'epidemic' to go unchallenged. Gard and Wright point

out that health surveys measure the number of cases of a condition in a given population at a certain time (prevalence), but rarely measure the number of new cases (incidence) arising over a period of time. Surveys therefore present a static 'snapshot' of a population and are not suited to make claims about the number of new cases of obesity, rates of change or predictions of future cases. According to Gard and Wright, survey data are often used to make moral and ideological judgements as much as epidemiological ones. It is in the interests of certain claims-makers to put forward a simple, memorable message of widespread prevalence. Once this is achieved audiences are more likely to be receptive to further claims that the condition is undesirable and in need of change.

1.2.3: The condition is undesirable.

"Obesity and overweight increase the risk of the biggest killer diseases, such as heart disease, cancer and diabetes." (Department of Health, 2004a: p. 1).

"Rich people have always tended to fatness, because they had access to rich foods and a disinclination to physical work…Now, the ex-working class are suddenly in the same position, but with even less understanding of the need for self-discipline." (North, 2004: online)

"Fat is on trial, but until now the defence has been mostly absent from the court of public opinion." (Campos, 2004: p. 14)

After establishing that a condition exists and is widespread, the next task for claims-makers is to construct it as undesirable and therefore in need of change. Claims about undesirability typify the condition itself and the people associated with it. These people may be individuals or groups and may be characterised as 'victims' or 'villains' according to the role they play in the cause and existence of the problem. As these terms suggest, claims about undesirability simultaneously express moral claims about normatively correct and incorrect behaviour. The undesirability of obesity is an area of much debate amongst claims-makers. Disagreement exists over why it is undesirable and whether it should be viewed as a problem at all. Despite the resources and hierarchical position held by the medical and governmental claims-makers promoting it, the argument that obesity is a health problem (medical model) can be seen to compete with alternative claims positioning it as a moral failing and a problem of discrimination. As a heuristic device, these positions can be characterised as the medical, moral and political 'models' of obesity.

The medical model

In the medical model obesity is undesirable because it is associated with ill health. An obese individual is a sick individual. This is the model put forward by various medical and governmental organisations, including the World Health Organisation (2000; 2006), the International Obesity Task Force (2005) and the UK (see below) and US (e.g., National Institutes of Health, 1998) governments amongst others. The Department of Health report (2004a), quoted above, links the excessive amounts of body fat that cause obesity to an increased risk of heart disease, type 2 diabetes, and some forms of cancer. Other

reports add further co-morbidities including, high blood pressure, osteoarthritis, mobility problems, skin problems and infertility (Wellcome Trust, 2005; National Institute for Health and Clinical Excellence, 2006; Dr Foster Research, 2008;) and calculate that these various problems can reduce life expectancy by 9 years (National Audit Office, 2001). Government reports also stress the punitively high financial costs of treating obesity for the NHS (up to £500 million per year) (National Audit Office, 2001; Wanless, 2007) and the wider economy (£1 billion per year) in terms of sickness absence and premature death (National Audit Office, 2001; Department of Health, 2004a).

Medical accounts converge around an energy in – energy out model of bodyweight. This states that weight is gained when an individual takes in more energy through calories in food and drink than he/she expends through activity and exercise (e.g., Wellcome Trust, 2005). This model has been challenged by alternative scientific claims that obesity can be caused by a virus (Kowalski, 2005) whilst developments in genetic research have added new strands to the model. One strand states that individuals may inherit traits which limit their capacity to regulate the energy in - energy out balance. Research so far indicates that a single gene very rarely determines obesity in an individual (Kumar, 1998) but that multiple genes can increase susceptibility to it (Farooq and O'Rahilly, 2007; Kaiser, 2007), in particular in interaction with the environment (Marti, Moreno-Aliaga, Hebebrand and Martinez, 2004). So far over 250 genes have been linked to weight management, (Sorenson and Echwald, 2001) including genes which influence fat storage (Hulver, Berggren, Carper et al 2005) appetite (Wynne, Park, Small et al), food choice (Keskitalo, Tuorila, Spector et al, 2008) and

weight regain after weight loss (Rosenbaum, Goldsmith, Bloomfield et al, 2005). Modern rises in obesity rates can be explained by the fact that advances in medical technology now enable obese people to live long enough to reproduce and pass on their genes (Ellis and Haman, 2004). A broader genetic strand explains that our bodies have evolved in a way that makes them vulnerable to weight gain (e.g., Kelner and Helmuth 2003; Hill, Wyatt, Reed and Peters, 2003). This historical narrative argues that through the majority of human history people were faced with the threat of famine. Therefore bodies which were most capable of maintaining weight and avoiding weight loss were naturally selected for survival. For the first time – in the West at least – we now live in a world of food abundance, but our bodies are still designed to keep weight on. For this reason we are becoming bigger and facing an obesity crisis.

Within their own logic, genetic models cannot entirely explain the apparent modern increases in obesity rates, since genetic adaptations are assumed to occur over a very long period of time. Instead, these studies often invoke environmental changes to explain that particular genetic traits are now coming to the fore. Typically they point to changes brought by industrialisation (Saris, 2005; Bellisari, 2007) and sometimes argue that modern levels of energy consumption and energy expenditure have created an 'obesogenic' environment which stimulates genetic susceptibility to weight gain (Ogilvie and Hamlet, 2005; Lean, Gruer, Alberti and Sattar, 2006; Foresight, 2007). These references to environmental factors can often be seen to go beyond apparently 'neutral', biological explanations. For example, Hill, Wyatt, Reed and Peters (2003) acknowledge a biological role in obesity but

blame increased prevalence on "aspirational values" which have "fuelled increased demand for getting better and better deals", leading to hugely increased consumption in return for less exertion, "that is getting more for less" (pp. 853-854). Here the obese individual shifts in status from being a 'victim' of ill health to become a 'villain' who has brought the illness of him/herself. Gard and Wright (2005) argue that these kinds of comments are common in the scientific literature and express moral as well as scientific concerns. Comments on environmental change construct a 'grand theory' of moral decline and enable scientific experts to make speculative moral claims about our current lifestyles. Gard and Wright use the example of nutrition experts who blame increased obesity rates in children on the (poor) quality of physical education in schools and the number of hours spent watching television, without providing any research evidence to support their claims. Such arguments are "not actually about food and physical activity at all" (p. 65). Instead, they are based on normative assumptions about behaviour. Similar normative assumptions can be seen in the moral model.

The moral model

Various claims-makers, including academics and pro-fat/anti-diet activists, have suggested that a moral model of obesity pre-exists the medical one. In this model individuals are responsible for their own bodyweight and obesity is caused by their laziness and greed. They are morally inferior 'villains' who have allowed themselves to become obese and who put a strain on wider society with their inappropriate behaviour. Some sociologists of the body and obesity (e.g., Bordo, 1993 Sobal, 1995 and Crossley, 2004) reference a historical narrative

that connects the emergence of the moral model to the onset of Western capitalism. This narrative states that in the period before industrialisation food was a scarce commodity in society. Having a large body was a sign that the individual could afford to eat well and so was esteemed as a sign of wealth. However, the onset of modern capitalism saw an abundance and cheapness of food in the West. Since everyone could afford to become fat, fatness ceased to be a special characteristic. At the same time, capitalism's work ethic stressed the virtue of hard work and delayed gratification. Consequently, a thin body came to symbolise effort and self-discipline whilst a fat body signified laziness and the inability to avoid temptation. In this model, obesity is undesirable because it demonstrates the moral weakness of the individual and requires others to make allowances for his/her lack of control.

The quote from North (2004) at the start of this section expresses very moral attitudes towards obesity and supports claims by authors such as Bordo (1993), Sobal (1995) and Crossley (2004) that the moral model persists in some form despite the successes of medicalisation. Furthermore, opinion surveys have consistently suggested discriminatory attitudes. A 1982 survey by Vener, Krupka and Gerard (1982) reported that US undergraduates said they would be more reluctant to marry an obese person than a communist, and were as reluctant to marry an obese person as they were to marry a prostitute. In a 2005 issue of the online magazine personneltoday.com, Thomas (2005) reports that 93% of Human Resources professionals surveyed said they would choose a normal weight applicant over an obese one with identical qualifications. In another issue of the same magazine (personneltoday.com, 2005), an employment barrister advises that this

choice is legal "provided there is no medical reason for the obesity". This sets up a distinction between the 'deserving' (victim) and 'undeserving' (villain) obese. Some feminist researchers (e.g., Bordo, 1993; Wiles 1994) have added that, since women are more routinely judged on physical appearance alone than men, they are more stigmatised by negative attitudes towards obesity. Finally, comments about 'getting more for less', 'aspirational values' and excessive television-watching in the medical texts discussed above appear to resonate with the concepts of greed and laziness central to the moral model. This apparent merging of moral and medical models can also be seen in proposals to change the condition (see below). Meanwhile, the final model of obesity, the political model, is based on a rejection of them both.

The political model

The political model of obesity subverts the moral model and challenges the medical one. Rather than placing responsibility on the individual, it blames society and the medical profession for many of the negative consequences experienced by the obese. The obese individual is again the victim, but for reasons of prejudice rather than health. Society and its members are the discriminatory villains. This model is put forward by claims-makers from pro-fat and anti-diet groups, feminist writers, writers of 'popular science' and 'converted' ex-dieters. They all advocate the acceptance of people regardless of their weight status, and some critique the available 'facts' on obesity. The work of Campos (2004) covers all of the issues central to the political model. He attacks the use of BMI to measure obesity in individuals and populations and states that evidence of the detrimental health effects of obesity is

overstated. For each piece of research on its negative effects, Campos cites alternative studies suggesting that increased bodyweight can lead to increased health, for example in protecting against osteoporosis, pulmonary disease and some cancers. Campos states that medical concerns about an obesity epidemic are simply a means to justify a cultural abhorrence of fat and that this abhorrence is perpetuated by the media and fitness industry amongst others. He concludes that the medicalisation of bodyweight is a reflection of deeper, societal concerns but that it is "easier to deal with anxiety about excessive consumption by obsessing with weight, rather than by actually confronting far more serious threats to our social and political health" (p. 19).

The three models of obesity alternately set up the condition as sickness, badness and individual difference. Tensions between, and sometimes within, these models complicate its presentation as an undesirable condition. As discussed next, these differences also have consequences for discussions on how the condition should be changed.

1.2.4: The condition can be changed

"And if there is a problem, who should be doing something about it? Is it just down to people to show more self-control?"
(Wellcome Trust, 2005: p. 1)

So far this chapter has shown that a great amount of social problems work has been conducted in the UK to convince audiences that obesity is a widespread problem in need of change. Its dominant portrayal as a medical problem is challenged by moral and political models which alternately construct obesity as a symbol of moral failure and a source

of discrimination. The final part of social problems work is to demonstrate that the condition can be changed. Here the UK government as policy maker is both claims-maker and the audience for other claims. Therefore obesity policy is outlined in a separate section of this chapter and the following section focuses on other sources of literature.

Claims-making about change is once again fragmented and competitive, both within and between models. However, proposed solutions always invoke social change. Furthermore, they all deal with the themes of responsibility and control. In different ways they attempt to resolve questions of who is responsible for the obese individual and who should take control of solving the problem. At times, they can be seen to reach similar answers despite beginning from competing assumptions.

Change in the medical model

The medical model solution to obesity is simple: lose weight. Since gaining weight threatens health, returning to a 'normal' weight will remove that risk. It can be achieved by reversing the energy in – energy out balance so that more energy is expended than taken in by the body. Despite this straightforward solution, how weight loss is to be achieved is a matter of dispute. Differences arise through competing accounts of how the energy balance should be reversed and how much control and responsibility the 'sick' individual takes for his/her own treatment.

For many years, diet and exercise interventions have been the 'gold standard' medical treatments for obesity (Garner and Wooley, 1991; Sobal 2003; Rossner, 2005; Gard and Wright, 2005). They function to decrease energy in (diet) and/or increase energy out (exercise) to encourage weight loss. This often occurs under the medical surveillance of a practitioner (or the quasi medical gaze of commercial weight loss organisations) making the individual a 'patient'. As diet and exercise activities are behavioural changes occurring throughout daily life, they require significant personal effort from the patient. Patients are also expected to exercise control over their treatment and take some responsibility for their progress.

Proponents and critics of diet and exercise regimes acknowledge that they have limitations. Firstly, research has not been able to determine the optimum way they should be carried out (see below). Is it better to both reduce energy in and increase energy out or is it enough to do just one? What forms of exercise are best for weight loss? If someone is so overweight they can do little more than walk, is that a sufficient form of exercise? Should dieting occur through a reduction of all foods consumed or just certain types of food? Does it matter from where in the body weight is lost? What if the patient's excessive consumption is associated with psychological issues? A 2003 Health Development Agency evidence briefing reviews research on the most frequently prescribed forms of diet and exercise. It deals with low-calorie diets, very low calorie diets, low fat diets, dietary fibre regimes, physical activity alone, physical activity combined with diet, behavioural/cognitive therapy and interventions targeting specific areas of fat collection in the body. This amounts to a broad range of potential solutions, which are at times incompatible, but the briefing does not

identify one single most effective intervention. More recent reviews (National Institute for Health and Clinical Excellence, 2006; Foresight, 2007; Dr Foster Research, 2008) have reported similarly inconclusive findings.

The second problem is that diet and exercise interventions are less successful in medical and research practice than the energy in – energy out model suggests they should be. Patients often lose less weight than predicted or regain weight soon after losing it (Garner and Wooley, 1991; Ashenden, Silgay and Weller, 1997; Elfhag and Rossner, 2005; Herbert and Bo, 2005). To critics this provides evidence that diets and exercise are not useful cures for obesity, whilst others defend them by placing blame for lack of success elsewhere. Winkler (2005) explains that limited success in diets occurs because medical and research "subjects" tend to "misreport what and how much they eat," (p. 199). They under-report their food intake meaning that their diets appear 'better' than they really are and that practitioners are unable to deliver relevant advice. Others claim that diets and exercise tend to fail because practitioners do not present them to patients efficiently. For example, Ashenden, Silgay and Weller (1997) argue that general practitioners (GPs) need to make more effort to offer advice and information about lifestyle change and Hitchcock-Noel and Pugh (2002) argue that practitioners do not advise their patients correctly as they are cynical about the success of diet and exercise regimes as well as about patient compliance with them. By stressing the importance of compliance and the correct reporting of behaviour, these claims present patients as largely responsible for their treatment. Furthermore, by referencing practitioner advice-giving, they also indicate a central role for medical interactions in the treatment of obesity.

Two other medical model interventions exert greater influence over the body and so decrease the patient's control over and responsibility for weight loss. The first of these is pharmaceutical interventions which function to manipulate the body's biology in some way. At the time of this study, only a few such interventions were available on the NHS. Injections of the hormone leptin (which is connected to the regulation of appetite and metabolism) can cure some forms of extreme, genetic obesity (Kumar, 1998; Marx, 2003), whilst available drugs influence the body in difference ways. Orlistat (also known by the trade name Xenical) stops the body absorbing some of the fat from food (Foxcroft and Milne, 2000), sibutramine (also known by the trade name Reductil) reduces feelings of hunger (Nisoli and Carruba, 2000) and rimonabant (also known by the trade name Accomplia and available for a short time on the NHS[1] in 2008) inhibits receptors in the brain to reduce the individual's desire to eat (Gura, 2003). Of these interventions, only leptin can 'cure' obesity by itself. The three drug based treatments are intended to help reverse the body's energy balance by complementing the individual's dietary and exercise efforts. Some commentators in this field are optimistic that further discoveries – especially those associated with genetic research – will enable the development of new pharmaceutical interventions (Kelner and Helmuth, 2003; Jha, 2004; Saris, 2005). However, others are more pessimistic, pointing out that existing pharmaceutical interventions have not proved particularly superior to diet and exercise regimes (Foxcroft, 2005). This creates a

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[1] It received European Commission approval in June 2006 and a National Institute for Health and Clinical Excellence (NICE) appraisal detailing its use in the NHS in June 2008. However, following further European Commission advice this guidance was withdrawn in October 2008 as rimonabant was seen to carry unacceptably high risks of side-effects relating to serious psychiatric disorders (see National Institute for Health and Clinical Excellence, 2008 a and b).

suspicion that future interventions may also prove disappointing, in particular since the biology of obesity appears too complex and varied to be influenced by a single drug (Astrup, O'Hill and Rossner, 2004).

Some other claims-makers suggest that if diet, exercise and pharmaceutical interventions are unsuccessful, another treatment can be applied: surgery. (e.g., Hitchcock-Noel and Pugh, 2002; Jain 2005). Bariatric surgery involves stomach banding or bypassing, drastically reducing the amount of food the body can absorb at any particular time. The individual must then reduce his/her food intake or risk serious discomfort and possible side-effects (Kral, 2006). Although the stomach banding operation is reversible in theory, it is usually intended as a permanent intervention (Kral, 2006). Surgery therefore acts as a form of permanent, enforced dieting, over which – apart from the initial consent – the individual has limited control. Where advocated as a solution to obesity, it is generally put forward as a 'last resort' to be carried out if diet, exercise and pharmaceutical interventions have been unsuccessful (Jain, 2005).

A final solution put forward in the medical model is the prevention of obesity through environmental changes. These changes might include health campaigns, the regulation of the food industry, exercise regimes in schools and the workplace etc (Sorenson and Echwald, 2001; Hill, Wyatt, Reed and Peters, 2003; Jebb, Lang and Penrose, 2003). The logic runs that the energy in – energy out balance of the entire population will be changed for the better, thereby avoiding the onset of obesity (but not attending to those already obese). Preventive measures are not necessarily incompatible with other forms of medical

change but they do compete for priority and funding (Campbell, 2004).

In an editorial in the journal "Obesity Reviews", Astrup, O'Hill and Rossner (2004) warn against relying on the development of new (gene based) treatments and call for "a long-term [preventive] strategy" before concluding that "the real heroes for obesity are going to be the scientists that develop successful ways to intervene in the population to prevent weight gain." (pp. 126-7). Of all the medical solutions to the obesity problem, preventive measures allow the individual least control. In effect, the individual changes without making a decision to do so or even realising that anything is different. Instead, control lies with medical and governmental institutions.

Medical model solutions to obesity take the form of diet and exercise, pharmaceutical, surgical and preventive interventions. As this review of the literature suggests, there is a vast amount of debate in the medical community over these different interventions. Much of this debate concerns which interventions are most effective on an individual and population level, but it also sometimes refers to more normative/ethical questions. For example, it is recognised that there is not enough funding available to finance all possible solutions. Ian Campbell (2004: online), a GP and one-time president of practitioner group The National Obesity Forum, warns that an emphasis on prevention has implications for the treatment of the already obese. Noting that some Primary Care Trusts in the UK have instructed GPs not to prescribe anti-obesity drugs, Campbell states that this instruction "unethically disregards potentially fatal repercussions [to the obese person] such as heart disease and cancer". An alternative argument is that if patients are obese but with no associated health problems, doctors should refrain from "infringement on their liberty" (Isaac and Isaac, 2004: p. 2095)

and need not regard their bodyweight as a medical issue (Rubin, 1994); whilst yet another argument states that obese patients should be required to lose weight before receiving medical care for certain health problems associated with obesity (such as polycystic ovary syndrome, see Balen, Dresner, Scott and Drife, 2006). Finally a broader debate concerns how far anyone indulging in 'lifestyle' behaviours such as smoking, drinking and overeating is entitled to any form of treatment to cure health conditions, such as cancer, liver cirrhosis and obesity that their behaviours have 'caused'. For example, in a British Medical Journal commentary piece, Gillies and Sheenan (2006) note the "powerful" (p. 279) argument that "[p]eople should be allowed to live their lives as they see fit, but when this goes against the generally received (medical) wisdom society is required to do only a limited amount to redress the consequences of those choices" (p. 279). They then cite genetic and psychological factors as circumstances in which this argument can be overlooked. Once again, this marks a distinction between a 'deserving' and an 'undeserving' obese person and indicates that medical interest in lifestyle conditions can extend into 'non-medical', social areas.

These kinds of debates about obesity treatment can be viewed in terms of the privileges and obligations of the 'sick role' (Parsons, 1951 and 1975). In this classic typology, Parsons describes the behaviours and 'responsibilities' associated with illness as a form of legitimised social deviance. Individuals within the sick role are granted temporary exemption from certain social responsibilities and are regarded as not responsible for their condition. In return, those individuals are required to make efforts to exit the sick role by seeking expert medical help, having the condition confirmed by an expert and making an effort to

get better. All proposed obesity interventions – with the exception of preventive ones – require the patient to make a personal effort to lose weight, with diet and exercise regimes requiring a considerable degree of effort. However, except in the case of surgery, obese patients are also expected to continue their day-to-day activities with few exemptions. Crucially, the 'undeserving' obese, who have caused their weight gain through their lifestyle behaviours can be regarded as responsible for their own condition. Once the patient is blamed for the onset of obesity, both sick role privileges are lost, leaving only the obligations. The obese patient is required to make an effort to lose weight without necessarily having the benefit of being legitimately labelled 'ill'. In addition to invoking the sick role, medical arguments which emphasise the responsibility of the individual for causing an undesirable condition, can also be seen to converge with moral model arguments.

Change in the moral model

The moral model solution to obesity is also to lose weight, but for very different reasons than in the medical model. According to the moral model, fatness is a social problem because it displays the inadequacies of the individual. The problem is solved when the individual overcomes these inadequacies and becomes socially acceptable. Since weight gain is caused by greed and lack of restraint (leading to excessive food intake or lack of exercise), a "triumph of the will over itself" (Campos, 2004: p. 19) will lead to acts of self-restraint that reduce consumption and increase energy expenditure, resulting in weight loss.

In the moral model the individual is required to change him/herself without the benefits of other people's taxes, sympathy, medical expertise or the privileges of the sick role. There is a general lack of overt moral model suggestions for change in most claims-making literature, although some personal opinion pieces do employ arguments contrasting the cost of treatment with an obese person's entitlement to medical care. In an opinion piece for The Times commenting on proposals that the NHS could pay for obese people to attend commercial weight loss groups, journalist Daniel Finkelstein asks "[w]hy should the NHS pay for people to behave in an approved manner?" (2004: p. 12). This mirrors one of the debates noted in the medical model, although expressed with different wording. More explicitly, Richard D. North (2004), editor of online magazine livingissues.com, placed on his website a list of "10 propositions on obesity and rationing treatment for it". Proposition 3 states that "[t]he GP stands some chance of exerting a stigmatising influence, even if everyone else in society is condemned to recognise the blobby diversity fat people represent."

In the moral model the individual is held responsible for the problem of obesity as well as its cure. The content of that cure resembles the medical model in recommending diet and exercise changes. However, whilst the medical model demands that the individual exercises control over food intake and energy expenditure to reach better health, the moral model demands that the individual exercises control over food intake and energy expenditure to reach normative acceptability. Both also require individual self-control and responsibility and position weight loss as a successful outcome.

Change in the political model

In the political model, the problem of obesity lies not with the fat individual but with the wider population. Individually and collectively, people disadvantage the obese by discriminating against them and pressurising them to be thin. Change must therefore involve a collective shift in attitudes. For claims-makers within this model the problem will be solved when thinness is no longer regarded as the only acceptable body weight. As discussed by Sobal (2003), activities conducted to advance this change include political lobbying for anti-discrimination laws or changes to advertising practices, publicity events and the establishment of support groups and internet based communications. They may be conducted by pioneering individuals or special interest anti-diet/pro-fat groups. According to Sobal, claims-makers in the political model represent a "small yet different voice" (p. 84), politicising the body and making it difficult for any government to adopt an overtly judgemental tone about obesity. Governments may prefer everyone to be a 'normal' healthy weight but they must remember that obese people can vote too.

Although population-level changes are advocated, political model solutions begin with the individual. People need to take control of their own lives and bodies since by doing so they so will undermine society's stigmatising tendencies and the controlling advance of capitalism and medicine. In her book "Fat chance! The myth of dieting explained", Ogden (1992), calls on (female) readers to recognise and reject the ulterior motives of diet companies who "make a profit out of women's feelings of inadequacy and promote the idea that dieting will make you thinner and more content with your life" (p. xi). Similarly, Campos

(2004: p. 18) encourages readers not to be taken in by the claims of the "profit maximising medical and pharmaceutical industry." So in the political model, primary responsibility for change rests on the individual. However, this assumption of responsibility is seen as a positive step rather than a negative one, as it empowers the individual to control his/her own body.

Claims about change complete the final element of work to establish obesity as a social problem. As with all elements of this work, there is no shortage of competing claims about change. Disagreement occurs within the medical model over how individuals' energy balance should be reversed and, crucially, how much control the individual can have over his/her own treatment. The moral model agrees that change should take the form of weight loss through individual effort but disagrees over why this should occur and the political model suggests a very different of change. As outlined below, the government primarily positions its response to obesity within medical policy, therefore suggesting that the medical model is dominant. However, just as medical and moral model proposals to change can be seen to merge at times, so government medical policy can also be seen to include some moral elements.

1.3: Government policy on obesity

"Preventing and managing overweight and obesity are complex problems, with no easy answers...[S]taff working directly with the public ...need to be aware of the many factors that could be affecting a person's ability to stay at a healthy weight or

succeed in losing weight. (National Institute for Health and Clinical Excellence, 2006: p. 4)

UK[2] government policy on obesity currently exists as a collection of published promises, principles and guidelines. After detailing the extent of obesity in England, the 2001 National Audit office report assesses existing treatment strategies for obesity as "patchy" (p. 2). It notes that most NHS treatment occurs in primary care, with only a small number of specialist centres available. It then recommends the development of new cross-departmental initiatives, to be led by the Department of Health. These initiatives should "set realistic milestones and targets" (p. 3) for improving the population's nutrition, diet and physical activity. The 2004 White Paper, "Choosing Health: making healthier choices easier", (Department of Health, 2004b) prioritises the need to tackle obesity. It pledges to allocate more funding to obesity management and prevention initiatives, set up an independent 'national partnership' providing research and information on management issues, produce a weight loss guide for individuals and act on forthcoming NICE guidance on clinical treatment (see below). The White Paper led to the publication of action plans on "Choosing a better diet" (Department of Health, 2005a) and "Choosing Activity" (Department of Health, 2005b). These action plans are designed to help individuals undertake healthy lifestyle behaviours through the provision of better information, choice and access to facilities. They also outline plans for local and national government initiatives such as healthy food programmes in schools and the maintenance of public

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[2] The policy discussed in this section relates specifically to England, as fieldwork took place in an English hospital. However policy aims and guidance for medical treatment are broadly similar throughout the UK. See for example: Scottish Executive, 2003; Welsh Assembly Government, 2003.

spaces to encourage physical activity. The "change4life" initiative, quoted in the introduction to this thesis, is one example of a nationwide anti-obesity project. Meanwhile the government states that its overall aim is to "halt the year-on-year rise in obesity among children under 11 by 2010, in the context of a broader strategy to tackle obesity in the population as a whole." (Department of Health, 2004b: p.2).

These policy proposals are put forward by the Department of Health. The government can therefore be seen to treat obesity as a medical problem and adopt the medical model of the condition as a social problem. In keeping with this, policy includes elements of the various proposals for change put forward by the medical model: diet and exercise regimes, clinical interventions and prevention. However, the 2001 National Audit Office report terms obesity a "lifestyle issue" which "the Department of Health cannot by itself be expected to cure." (p. 1). This suggests that individuals should also take some responsibility for obesity. In a 2006 speech, then Prime Minister Tony Blair stated that obesity, smoking, alcohol abuse, diabetes, and sexually transmitted diseases are "not strictly speaking, health problems at all" but "questions of individual lifestyle… the result of millions of individual decisions, at millions of points in time" (news.bbc.co.uk, 2006). He continued that the government's role is to empower people to follow healthier lifestyles, "setting the conditions in which they can choose responsibly." (as above). This presents obesity as a simultaneous individual choice and responsibility. As such, it invokes moral concerns about the condition, which have already arisen in this chapter and which continue to be crucial throughout this thesis.

The National Institute for Health and Clinical Excellence (NICE), a part of the NHS, is responsible for providing clinical guidance for healthcare practice in primary, secondary and tertiary NHS care. In 2005, it published "Social value judgements: Principles for the development of NICE guidance" (National Institute for Health and Clinical Excellence, 2005; see also 2008 second edition). This was developed by the Institute board with input from advisory bodies and a 30 member 'Citizens Council'. The document sets out the "ethical principles, preferences, culture and aspirations that should underpin the nature and extent of care provided by the NHS." (p. 7). The tenth principle states that: "NICE and its bodies should avoid denying care to patients with conditions that are, or may be self-inflicted (in part or in whole). If however, self-inflicted cause(s) of the condition influence the clinical or cost effectiveness of the use of an intervention, it may be appropriate to take this into account." (p. 5). Where it is non-genetic, obesity can be seen as one of these 'self-inflicted' conditions and there is therefore a warrant to use an individual's lifestyle behaviours as a justification to deny him/her care. Once again, this has resonance with the sick role's association of being 'legitimately' ill with not being responsible for one's own condition, here suggesting that those who have caused their own illness may be denied certain forms of medical attention. It also has resonance with the moral model's denial of full personhood to those whose actions have created their own obesity.

In 2006 NICE published "Obesity: guidance on the prevention, identification, assessment and management of overweight and obesity in adults in children" (National Institute for Health and Clinical Excellence, 2006). This sets out detailed guidance on the medical treatment of obesity in the NHS, based on evidence of clinical and cost

effectiveness. Although it focuses on clinical interventions, it states that "there is no simple solution" to the problem of obesity and that "clinical management...cannot be viewed in isolation from the environment in which people live." (p. 5). It also recommends that "everyone should aim to maintain or achieve a healthy weight" (p. 13). The sections dealing directly with clinical management state that practitioners should use the BMI to identify obesity in adults, but that this may be combined with other measures. It recommends "multicomponent interventions [as] the treatment of choice" (p. 42) and states that all obesity treatments should include behaviour change strategies relating to diet and exercise activities. Pharmaceutical interventions can only be considered (for adults) once behavioural changes have been attempted and the patient has been unable to reach his/her target weight. Orlistat and sibutramine[3] can then be prescribed, but treatment should continue beyond 3 months only if the patient has lost 5% of his/her initial body weight and regular reviews are necessary to monitor "the effect of drug treatment and to reinforce lifestyle advice and adherence" (p. 52). Surgery is also available for adults if all other appropriate clinical measures have been unsuccessful, if the individual is likely to benefit from the surgery and if intensive, specialist support is available. By emphasising the importance of lifestyle change and meeting weight loss targets, these guidelines position patient effort and control as central to the conduct of treatment.

As well as outlining the interventions practitioners can provide to obese patients, the document also states how practitioners should provide them. It recommends that "health professionals should follow the usual

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[3] Similar guidance was produced for the prescription of rimonabant in 2008 (National Institute for Health and Clinical Excellence, 2008a)

principles of person-centred care" (p. 7) by taking patients' individual needs and preferences into account and providing opportunities for informed decision making. It also states that "[g]ood communication between health professionals and patients is essential." (p. 7) noting that it is necessary for practitioners to discuss with patients any potential barriers to lifestyle change, to tailor advice-giving to individual needs, discuss the available range of clinical options, negotiate with patients over the form treatment should take, use jargon-free language, "aim to improve people's belief in their ability to change (for example, by verbal persuasion…)" (p. 19) and "praise successes – however small – at every opportunity" (p. 43). Patients should have the opportunity to discuss dietary concerns with their practitioners but are also required to report on any previous weight loss efforts plus display that they are committed to discussing their weight and able to make lifestyle changes.

These policy and guidance documents present two themes of particular relevance to this study. The first of these, as already indicated, is the importance of control, effort and responsibility in clinical medical treatments for obesity. All treatments are based on lifestyle modifications, requiring continued effort and personal control from the patient, who also takes some responsibility for success. If prescribed pharmaceuticals, patients are expected to persist with their diet and exercise efforts and to endeavour to meet weight loss targets. Surgical interventions remove much control and responsibility for success from the patient, but still require some effort to modify eating behaviour and to attend continued medical monitoring.

The second theme is the importance of interaction between practitioners and patients during obesity-related consultations. All medical encounters involve a range of verbal activities, e.g., descriptions of patient behaviours and efforts, delivery of diagnosis, assessments of progress and advice-giving. These activities are particularly important in obesity consultations since most treatment, especially in the form of lifestyle changes, occurs away from the medical gaze. Patients are required to report their treatment behaviours in a way that promotes medical discussion and in turn practitioners are required to make assessments based on these descriptions and produce advice about further treatment. In this way talk can be seen as not only the medium through which treatment is delivered, but as the content of treatment itself. The NICE guidance also promotes additional roles for talk, for example in its recommendations that patients display commitment to change and that practitioners praise them for success. The guidance demands 'good' communication without defining what that means or how it is to be achieved and assessed. This suggests the value of analysing talk in obesity-related consultations, in particular to investigate how 'good' communication might be affected by the themes of responsibility, effort control and legitimacy recurring throughout the literature.

1.4: Discussion

In this chapter, I have discussed existing medical, scientific, government and interest group literatures on obesity. By adopting a constructionist approach I described how different claims-makers attempt to establish obesity in the UK as a social problem that needs to be addressed. This claims-making work is fragmented and competitive

and can be seen to construct three 'models' of obesity. The dominant medical model positions obesity as a health problem caused by an energy imbalance in the body and 'cured' by a reversal of that imbalance. The moral model appears to contradict the medical one by positioning obesity as an individual failure of laziness and greed. However, it agrees with the medical model that obesity can be 'cured' by weight loss and shares an emphasis on individual effort and responsibility for change. These themes are in turn taken up by government guidelines on the treatment of obesity. The political model, promoting the right of the individual to be different and overcome prejudice, tends to be overlooked in government recommendations that all citizens should take care to maintain a healthy weight.

In my discussion of this literature I have adopted a constructionist approach to the social problem of obesity. I have described how the - often competing – activities of claims-makers serve to present the condition as widespread, troublesome and in need to change. Emphasising the constructed status of obesity does not argue that it is not in fact 'real' or that it does not have 'real' consequences in social life. The UK government's treatment of obesity as a health issue is a key example of an actual consequence of this constructed social problem. As described above, current health policy sets out ways in which obesity should be identified, defined and managed in the population. These policies have practical implications for healthcare workers and their patients, regardless of debates over how 'serious' the problem is or the validity of the BMI etc. These practical implications are open to sociological analysis; for example in terms of how the condition is managed and in the medical setting and how policy guidelines are translated into action. Consequently, although this thesis

discusses obesity as a constructed condition, matters of obesity practice are central to the analysis.

This discussion of the literature raises further issues relevant to sociological study of obesity in general and to my study of doctor-patient interactions in particular. The first of these is the apparent similarities between the medical and moral models of obesity. As noted above, both models advocate weight loss to be achieved by the individual taking responsibility for his/her own condition and making an effort to change. Furthermore, whilst obese individuals in the medical model are technically 'victims' of ill health, they are sometimes transformed into 'villains', adopting undesirable lifestyle behaviours and perhaps undeserving of some medical help. These normative themes are also evident in government policy on obesity, for example in the suggestion that individuals with 'self inflicted' conditions may be refused treatment and the recommendation that obese individuals must display commitment to change to warrant treatment. If these moral issues are evident in the literature, might they also be evident in medical practice? How might competing medical, moral and political arguments about obesity be influential in the conduct and outcome of consultations or shape the actions of those involved in them?

The second issue concerns the importance of talk in medical consultations about obesity. Interactions between practitioners and patients are crucial to these encounters since lifestyle behaviours and weight loss treatments cannot be observed during the consultation and instead need to be described verbally, both in reports from the patient and recommendations from the practitioner. Talk becomes a form of treatment in itself and is therefore a valid subject for analysis.

Furthermore, it is relevant to consider whether some of the other issues observed in this chapter might be present in the talk. For example, might interactants refer to different models of obesity in their talk and how might this have consequences for the subsequent discussion? Is it possible that patients might invoke political arguments to resist recommended treatments, or that practitioners might be heard to move between moral and medical models in their descriptions of the patient's status and progress? References to 'responsibility' and 'effort' can be heard as simultaneously moral and medical, just as lifestyle behaviours can be seen as both private matters and justifiable medical topics. These factors suggest that obesity could be a very 'sensitive' topic to discuss in a medical setting.

The final issue is a methodological one. This chapter has presented obesity as a constructed social problem, a product of a particular space and time. Do we accept that as researchers we cannot access the 'real' condition and if so, how can we go on to study it further? Do we focus on investigating how it is constructed or find means to study the effects and consequences of its construction? As the next chapter shows, these issues are central to the status of current sociological work on obesity and present empirical problems that interactional approaches are able to overcome.

Chapter 2: Review of social scientific literature relevant to obesity and medical interactions

2.1: Introduction

In the previous chapter I discussed how medical, scientific, government, research and interest group literatures work to establish obesity as a social problem in modern society. I also described how current UK government guidance sets up talk between practitioners and patients as central to the medical 'cure' for the condition. I now look at the social scientific literature relevant to obesity and medical interactions.

There is a growing sociological interest in obesity and this work puts forward a range of understandings about how the condition 'exists' and is understood in society. However as a new field, sociology regarding obesity has a number of gaps; in particular there is an absence of work investigating actual medical practice. As my interest lies in talk during medical consultations for obesity, this is a significant research gap. I also discuss some other areas of sociological research relevant to obesity. After noting insights from the sociology of food and the sociology of the body, I focus on a number of key studies in the sociology of medical interactions. These emphasise that medical encounters are achieved collaboratively through the talk between practitioners and patients. They also suggest that, despite changes in setting and actor, medical interactions often proceed in similar ways and are characterised by a polite, 'bureaucratic' style of communication. However, interactional tensions can occur when issues connected to patient responsibility, rationality and lifestyle behaviours

are discussed – issues that are very likely to arise in obesity-related medical consultations. These literatures build up a body of insights relevant to the topic of my study and also point to a methodological framework for the analysis of medical talk.

2.2: Sociological perspectives on obesity.

"A year ago we suggested a logical division of medical sociology into two categories, the sociology of medicine and sociology in medicine. We suggested that the sociology of medicine is concerned with studying such factors as the organisational structure, role relationships, value systems, rituals and functions of medicine as a system of behaviour... Sociology in medicine consists of collaborative research or teaching often involving the integration of concepts, techniques and personnel from many disciplines." (Straus, 1957: p. 200)

In 1957 Robert Straus distinguished alternative directions in medical sociology. The key difference between them, expressed through the terms 'in' and 'of', lay in the framing of the central concepts of investigation. Sociology 'in' medicine takes its concepts directly from medicine, using established terminology and definitions as the starting point for research and often conducting studies with the co-operation of the profession. In contrast, sociology 'of' medicine engages critically with these terminologies and definitions, treating them as objects for analysis. Analysis therefore seeks to uncover hidden assumptions about medical practice and place them in a wider sociological context. The boundary between the two may not always remain clear-cut in practice but the distinction retains analytic value. Here I adapt it to discuss

existing sociological work on obesity. As medical and social concerns about the condition have grown, sociological interest in obesity has also increased. Within this interest it is possible to distinguish the existence of a sociology 'in' obesity and a sociology 'of' obesity. Sociology 'in' obesity adopts medical definitions as a starting point for analysis and often uses official statistics to explore the social dimensions of the condition. By contrast, the sociology 'of' obesity analyses these definitions, statistics and concepts to consider the structures, relationships and values that underpin them. As a result it often takes a critical stance towards claims about the current obesity 'epidemic' and challenges the findings of sociology 'in' obesity. Within this debate over how far obesity exists as a 'real' phenomenon, the fact that many individuals labelled as obese experience medical treatment for their condition – and that this represents a worthwhile area for analysis – has tended to be overlooked.

2.2.1: Sociology 'in' obesity

"While it is widely believed that the current obesity epidemic reflects imbalances in energy intake and expenditure, the nature of these imbalances, their social, cultural and environmental determinants, and why they might differ by occupation are not well understood. It is plausible that occupation or education may influence obesity-related health behaviours...and these in turn influence energy intake/expenditure and metabolism, which influence obesity."
(Ball and Crawford, 2005: pp. 2007-8)

Sociology 'in' obesity does not necessarily deny that obesity is constructed (see Crossley, 2004, below), but seeks to investigate the relationship between the biological condition and society. This includes theoretical discussions plus empirical studies, often using quantitative methods. Statistical investigations have taken up official concerns over the connections between rates of obesity and demographic factors, seeking to explore them further. Studies in the US have suggested that the acknowledged inverse relationship between socio-economic status and obesity is particularly strong amongst women (Zhang and Wang, 2004) and that neighbourhoods with large black populations have a greater prevalence of obesity than mostly white neighbourhoods (Boardman, Saint Onge, Rogers and Denney, 2005). Ball and Crawford's (2004) review of studies in developed countries found similar inverse associations between occupational status and weight gain. In the UK, Power, Matthews, Stansfled and Manor (2005) analysed British birth cohort data and concluded that the chances of an individual becoming obese in adulthood were strongly influenced by his/her social position in early life, whilst Taylor, Viner, Booy et al (2005) found that adolescents in certain ethnic minorities were at increased risk of being both overweight and underweight.

Other studies have adopted survey and interview approaches to provide a deeper understanding of the dynamics behind the statistical distribution of obesity. For example, Batnitzky (2008) conducted interviews in Moroccan households and referenced her findings to population data, arguing that Moroccan women are at greater risk of obesity on account of their traditional household roles. In the UK, Chowdhury, Greenhalgh and Wood (2005) used survey data to argue

against the stereotype that British Bangladeshis are more likely to be obese because 'Asians like to be fat'. These kinds of study have some relevance to my research project as they indicate that certain non-medical features may influence what type of person becomes eligible for medical obesity treatment. However, they do not offer insights into what occurs during those treatments.

Studies 'in' obesity have also attempted to provide theoretical explanations for current obesity prevalence. Lakdawalla and Philipson (2001), Crossley (2004) and Qvortrup (2004) have all connected individual weight gain to the organisation of modern industrial societies. Focusing on the UK, Crossley argues that obesity rates are "social facts" (2004: p. 223) because they differ across space and time. As so many people are becoming obese at the same time, increases in obesity rates are also social facts and warrant sociological investigation. According to Crossley, sociology can provide a sophisticated model explaining how the lifestyle behaviours that "nutritionists, dieticians, psychologists and policy makers are all agreed is the cause of obesity" (p. 236) interconnect with each other and with external phenomena to drive current prevalence. For example, the simple observation that car use decreases physical activity and promotes weight gain can be expanded to consider the role of urban development, the geographical separation of home and workplace, lack of pavements and perceived high levels of pollution and danger in the streets. Each of these factors can be seen to facilitate or require car use, whilst simultaneously being shaped by it.

Crossley suggests that patterns of uneven obesity distribution according to class and gender can be theorised through Bourdieu's (1984) concepts of habitus and cultural capital. He also argues that individual responses to weight gain may be shaped by the "quite strong norms and ideals regarding body shape and weight in our society, which tend to centre upon slim, toned or athletic bodies, and which the obese individual deviates from." (Crossley, 2004 as above: p. 246).

Crossley argues that although obesity is a construct, it should be regarded as a 'real' condition since it has 'real' consequences across society. With his theoretical discussion he aims to "open up a sociological debate on obesity" (p. 222) and demonstrate that the condition does not solely 'belong' to other disciplines. Certainly this study and studies 'in' obesity generally, demonstrate that sociology can contribute to obesity research, particularly in investigating the role of social causes, attitudes and divisions. Therefore there is also a role for sociological studies to debate and comment on current policies. In terms of this study, sociological studies 'in' obesity indicate that an individual's route to becoming obese may be influenced by non-medical circumstances, which may in turn influence how problematic that individual perceives weight gain to be. However, the unproblematic adoption of official definitions and statistics can be seen to undermine the validity of these kinds of claims. Crossley states that obesity rates are social facts. However, in his original conception, Durkheim (1938) describes social facts as group practices, which are collectively understood and internalised by the individual to constrain behaviour. Collective weight gain is the social fact, not obesity. Obesity itself is an artificial concept and a constructed condition. This means that it is

difficult to base theoretical and empirical claims on existing definitions and statistics as they are also constructed. If we accept these reservations, we move towards a sociology 'of' obesity.

2.2.2: The sociology 'of' obesity

"Are the contemporary conditions of obesity and overweight real, or are they mere artefacts of the different methodologies and thresholds used at different places and time to construct them?" (Evans, Rich and Davies, 2004: p. 384)

The sociology 'of' obesity emphasises that definitions, descriptions and understandings of the condition are influenced by the context in which they are produced and the interests of those producing them. This begins with analyses of how obesity has come to be seen as a medical problem in modern life. As outlined in the previous chapter, several authors, including Sobal (1995) and Bordo (1993), have connected the emergence of a medical model of body weight to the developing authority of medical expertise and technologies and suggested that exists in competition with a moral model framing obesity as individual failure. Similarly, Jutel (2006) argues that where 'overweight' was once a description of an individual's physical appearance or a symbol of wealth and prestige, it has been transformed over time to be understood as a disease entity. Jutel attributes this transformation to widespread belief in the neutrality and objectivity of quantitative measurement, combined with the supposed normative relationship between appearance and health. In analyses of medical documents, Hacking (2007) has described how the BMI came to be the standard form of obesity measurement through a series of empirical discoveries and pragmatic decisions, whilst Chang and Christakis (2002) have

identified changes in how obesity is defined in medical textbooks. Chang and Christakis state that over seven decades these definitions have progressively lessened the degree to which the individual is held personally (and morally) responsible for his/her own condition. They argue that obesity has shifted in "ontological status…from being a product of something that individuals *do* to something that they *experience*" (p. 151 italics in original).

Recognition of the constructed, historically-contingent understandings of excess bodyweight enables further analysis into obesity as a contested category. As outlined in chapter 1, obesity can be understood through alternate medical, moral and political 'models'. Saguy and Riley (2005) argue that these models form the basis for 'framing contests' between anti-obesity and fat acceptance researchers and activists over how obesity is perceived in everyday life. Different actors have different levels of success. Sobal (2003) attributes the relative lack of success of attempts by the size acceptance movement to popularise the political model in the USA to their difficulty finding political and financial allies. Various studies indicate that, in comparison to marketing the ideal of thinness, there is little profit to be made from promoting acceptance of fatness (Sobal, 2003; Salant and Santry, 2005). Additionally, the media can be seen to have an interest in over-dramatising the seriousness and consequences of obesity (Boero, 2006; Saguy and Almeling, 2008) and in presenting it as a problem for the individual (Herndon 2005; Campo and Mastin, 2007).

Nevertheless, these dominant models and modes of presentation may not determine individual attitudes. A number of interview studies have indicated that, whilst individuals may demonstrate awareness of

obesity measures or accept their own obesity as problematic, they also explain and experience their weight in non-medical model ways. This includes via their personal histories, (Warin, Turner, Moore and Davies, 2008), through their own, often morally defined, understandings of what constitutes a healthy weight (Monaghan, 2005) and in terms that resist constructing weight gain as individual responsibility and failure (Throsby, 2007). These studies therefore suggest that individuals may resist both medical and moral attitudes about obesity.

Finally, a number of studies have viewed the perceived limitations of obesity science (see discussion of Gard and Wright, 2005 in chapter 1 plus Aphramor, 2005 and Monaghan, 2005) through issues of power. The emerging critical sociology 'of' obesity argues that current understandings and policies legitimise discrimination against obese individuals. For example, Evans, Rich and Davies (2004) argue that much of the current concern about obesity is mediated by moral attitudes favouring thinness over fatness. Evidence to support claims of an epidemic is often unreliable but is nevertheless used to associate thinness with health, reinforcing existing moral pressure. In a later paper, Rich and Evans (2005) add that the practice of erasing uncertainties about the relationship between health and obesity raises ethical questions as it may encourage oppression, discrimination and disordered attitudes towards the body. In some instances this kind of critical sociology merges with 'fat activism', promoting the political model of body weight (see LeBesco, 2004).

Studies in the sociology 'of' obesity emphasise the lack of consensus over a supposedly 'objective' and 'medical' condition. They raise interesting questions for my research project in terms of how far the

different medical, moral and political models may become visible in talk between doctors and obese patients. For example, patients may ascribe their weight status to non-medical factors, in ways consistent with the interview studies described above, or if invoking the political model, be resistant to medical interventions (if agreeing to medical discussion at all). Moreover, it is possible that the limitations of medical knowledge about obesity may also play a role in consultations. However, whilst provoking useful questions, these studies 'of' obesity share the familiar drawback that analysing how something is constructed tends to render the thing itself invisible (Latour, 2004). Whether actually 'obese' or not, many people labelled as such do enter into medical discussions about their weight, and whether governed by oppression, discrimination, resistance or 'neutral' medial science, these discussions do have analysable outcomes. There is a danger that emphasising the constructed and contested nature of obesity neglects to consider these outcomes and the social consequences they have. It remains necessary to investigate actual obesity treatments.

2.2.3: Sociology and obesity-related medicine

One point of agreement between sociology 'in' and 'of' obesity is that, despite some competition and interweaving between models, obesity is dominantly presented in modern society as a medical condition requiring medical treatment. Despite this agreement, sociology has so far paid little attention to obesity-related medicine. In the US some quantitative surveys have investigated how often practitioners advise patients to lose weight. Galuska, Will, Serdula and Ford (1999) analysed telephone survey data and found that, of those questioned, less than half of obese adults reported being advised by practitioners to lose weight. Those most likely to be given advice were women, the

middle aged, the more seriously obese and people with type-2 diabetes. Loureiro and Nagya Jr (2006) surveyed the same country-wide dataset and, acknowledging evidence that practitioners tend not to offer advice about losing weight, found that when advice was given, patients were more likely to take up weight loss practices including diet and exercise.

Some interview studies have also attempted to generate detailed descriptions of patients' reported experiences of weight loss attempts. Sarlio-Lahhteenkorva (1998) interviewed obese adults in Finland, most of whom were under medical weight loss supervision and all of whom had lost then regained a significant amount of weight. She argues that these relapse narratives provide an "insiders' perspective" (as above: p. 208) that can enable health professionals to develop meaningful obesity treatment. In particular she points to external support, expectations and values about the body and dieting as central factors to an individual's experience of weight loss that need to be incorporated into healthcare practice. In a similar study, Throsby (2007) interviewed pre and post bariatric surgery patients and asked them to narrate their own weight histories. She found three recurrent patterns in their narratives; they described themselves in terms of living in an innately fat body, located the roots of this in childhood and referred to specific life events as triggering behavioural changes that led to weight gain. Throsby argues that the narratives produced resist the discourse of the fat body as a moral failure enabling the interviewees to distance themselves from negative images of obesity. However, the interviewees also conveyed ambivalence towards those negative images as they did position failure to do something about

obesity as morally blameworthy, as emphasised by descriptions of their own decisions to undergo surgery. Throsby concludes that these narratives represent a "quiet, but significant resistance" (as above: p. 1750) to ideologies which state that obese people have 'let' themselves become ill through lack of willpower and self-control, but adds that this resistance is limited by the absence of opportunity for people to present these accounts.

Although they represent a small amount of research, sociological studies of obesity and medicine mark some points of interest for my research. The quantitative surveys point to a low incidence of advice-giving from practitioners (in primary care) about obesity. This is interesting as it could suggest that the framing of obesity as a medical problem is weaker in practice than the literature suggests. It could also suggest that obesity's associations with moral and social issues may make the condition difficult to discuss, leading to practitioner avoidance. Although the interview studies involve participants who have experienced healthcare treatments, they suggest that obese patients experience and perceive their bodies in wider terms that incorporate 'lifeworld' (Mishler, 1984) issues. This raises significant questions in terms of doctor-patient interactions: how might patients and doctors display different understandings of obesity and how might these affect the talk and outcomes of consultations? In particular, how might patient ambivalence or resistance towards moral issues of bodyweight simultaneously imply rejection of the medical model, which also positions obesity as an individual problem needing to be solved by weight loss? Interview and survey studies cannot answer these questions as they do not directly observe medical encounters, so how

these issues might be transformed into talk is a matter for alternative forms of investigation.

This review of the sociological literature on obesity has suggested a number of themes of relevance to my research study. Firstly, they make clear that sociology can contribute to the investigation of obesity and that this research can take different directions. In addition, they indicate that social factors may influence who becomes obese and the attitudes that they have towards their condition. By extension it is possible that these factors may become visible during talk in medical encounters. Furthermore, research into obesity and medicine suggests that issues of bodyweight and weight loss may rarely be raised in treatment and that when patients do undergo interventions, their understandings of obesity may differ from medical ones. However, it is not possible to assume that these themes exist in obesity-related medicine as there is an absence of studies directly observing treatment. This is an omission of content and a methodological omission. As a new field, sociology regarding obesity will contain research gaps; in this case the gaps concern issues central to my study. These are: what happens during medical treatments for obesity and how do practitioners and patients interact during these encounters? In methodological terms the absence of studies directly observing medical encounters limits the findings that can be made about obesity-related medicine.

Since the sociological literature on obesity is still relatively small, it is useful to look to other sociological fields which might be relevant to the study. As my research concerns talk between doctors and patients, the sociology of medical interactions is a particularly useful area to discuss. Furthermore, obesity connects to a vast number of areas of sociological

interest: gender, food, exercise etc. Therefore, it is likely that studies in these fields may also offer insights. In the rest of this chapter I discuss relevant studies in two of these fields – the sociology of food and the sociology of the body – before discussing the sociology of medical interactions.

2.3: Additional sociological perspectives

2.3.1: The sociology of food

As seen in the previous chapter, food has great relevance to obesity. Excessive food intake is regarded as problematic in different understandings of the condition, seen alternately as an imbalance to the body's energy ratio and as a consequence of individual greed. Reduced food intake is similarly seen as a solution to the problem, creating a change to the energy ratio or symbolising the acquisition of self-control. These understandings make it clear that food is not 'just' a neutral issue but is instead connected to normative concerns over proper behaviour. A number of studies in the sociology of food draw out these moral implications in a manner that offers both empirical and methodological insights for my study.

A central of theme of the sociology of food is that food and eating are associated with collective norms and form an inherently moral part of everyday life. Macro level studies have discussed how developments in the food industry might shape and be shaped by individual eating practices. For example, Wrigley (1998) discusses how the rise of large food corporations in the UK has transformed the idea of 'food choice' for the individual and enabled developments such as chilled, high-

calorie 'ready meals'. Micro level studies have considered how food is imbued with symbolic value and associated with group activities. From a structuralist position, food can be seen as a system of codes bearing collectively understood meanings. These collective meanings may influence individual food practices and do so in a way conflicts with official advice and that is stratified according to demographic characteristics.

A relevant example of this perspective is Williams' (1983) interview study of elderly middle and working class people in the Scottish city of Aberdeen. Williams reported that beliefs about food and health expressed by the interviewees were coded in a variety of ways. For example, rather than distinguishing between 'health' and 'illness', interviewees invoked 'health' and 'unhealth'; with the former referring to a reserve of strength and the latter referring to vulnerability to sickness as well as sickness itself. They also expressed deeply held beliefs about 'health food' and 'illness food'. 'Illness foods', such as fresh fruit and sunflower oil, are for treating specific illnesses, including arthritis, circulation problems, and poor digestion, and are often recommended by the medical profession. 'Health foods', include plain locally grown ingredients such as oats, berries, rhubarb and turnips. These deal with broader issues of unhealth and are seldom defined in reference to medical advice but are likely to be connected to life experience, for example in habits acquired in war time or in a long-held preference for locally grown food. At times, ideas about 'health food' conflict with those about 'illness food', and in those situations officially sanctioned guidance did not necessarily prevail. Williams also noted class differences in these attitudes. He suggested that the working class interviewees were more likely to subscribe completely to a

'Scottish rural tradition' ethic emphasising effort, home grown foods and outdoor work. By comparison, middle class people were more likely to value moderation and to report pursuing a less extreme, 'sensible' food regime. However, with regard to weight, the majority of the sample held similar views. 'Fat' people were criticised for consuming too much and overly 'thin' people were criticised for working too hard. These views, of course, resemble the moral model of body weight.

In an interview and focus group study, Henson, Gregory, Hamilton and Walker (1998) investigated the effects of an individual's planned dietary change on the entire family group. Amongst others, one of the frequent changes was a switch to a calorie controlled weight loss diet. The authors observe that the extent to which the individual's proposed change was accommodated by the rest of the family depended upon the willingness of the family 'food manager' – responsible for most of the organisation concerning mealtimes - to undertake changes for that individual or to negotiate a change across the whole group. Also relevant was the extent to which the change was regarded as legitimate. Whilst some proposed changes, e.g., vegetarianism, were challenged by the rest of the group, medically advised changes, such as slimming diets, were often regarded as automatically legitimate.

Henson, Gregory, Hamilton and Walker begin their study by noting that "academic discussions of food choice" (as above: p. 183) often ignore that most food is prepared and eaten in a social context. They go on to argue that selection of food cannot be understood in terms of individual preferences alone. A similar point can be made about the medical literature on obesity. This literature often seems to assume that eating merely functions to fulfil a biological need, and positions any kind of

'emotional' relationship with food as pathological. The sociology of food plays an important role in countering these assumptions by recognising that eating is a collective behaviour influenced by group norms and meanings relating to food. Weight gain caused by food intake and weight loss from dieting are part of this broader context. Once again, it is possible that the issues raised in these various studies – conflicts between medical and lay understandings of food, the importance of eating as a collective practice etc – may become visible when doctors and patients talk to each other in a medical obesity setting.

The final study discussed in this section directly takes up the issue of how people talk about food and obesity. It does so by using Conversation Analysis (CA), an approach which observes interactions in detail in order to identify common patterns in the way people communicate. In the study, Sneijder, te Molder and Wiggins (2006) analyse online talk on the message boards of a US weight loss organisation. They used a discursive psychology approach to discuss the psychological concept of attributions – explaining things and predicting future events. Instead of investigating how the attributions produced by the online users reflected their individual psychological status, the authors treated the attributions as (conversational) actions used to do particular things. By treating online talk as social action, this research also has relevance to sociology.

In the study Sneijder, te Molder and Wiggins analysed a collection of messages on threads in which obese dieters described 'lapses' in their weight loss regimes, caused by binges or cravings for certain foods. They found that the users' descriptions invoked issues of agency, responsibility and control and performed the action of managing blame.

They identified three patterns in the way this was achieved. Firstly, users reported their activities as if a witness to them rather than the agent of them. This enabled them to separate observation from evaluation and avoid making negative judgements about themselves. The second practice was to present the lapse as the inevitable outcome of a series of chronological events. Responsibility or blame for the lapse could then be attributed to external factors or a single act of the reporter rather than his/her overall character. The third practice was to present eating too much as a one-off and logical choice, for example as a reward for previous 'good' behaviour. Both explicit self blaming and denial of blame were absent from these descriptions. This enabled users to construct their identities as neither victim nor particularly guilty and therefore as generally in control of their own eating practices. Other website users also responded to these messages without explicitly attributing blame to the first reporter's own character.

This study suggests that moral issues of responsibility and control are present in interactions about food and weight. These findings are mirrored in another discursive psychology project conducted by Mycroft (2008), in this case observing interactions about food between group leaders and participants in commercial weight-loss groups. Mycroft concludes that "both the group leaders and group members could not orient to food without reference to a moral or accountable framework" (as above, p. 1040). This study was also conducted using conversation analysis. The benefit of this approach is that its use of detailed empirical description reveals not only that moral issues of responsibility and control are present in interactions, but also how they become present through interactions. Sneijder, te Molder and Wiggins (2006) show how this is achieved in a number of ways: in the vocabulary

employed by participants, e.g., 'I'm feeling guilty' differs from, and avoids saying, 'I am guilty'; in the unfolding of talk over time, e.g., the listing of the number of 'good' days that preceded a 'bad' day makes clear that the lapse was a one-off event; and in the responses of other website users who also avoid accusations of blame. The methodological benefits of conversation analysis are discussed more fully in the next chapter.

2.3.2: The sociology of the body

The sociology of the body is a diverse field that shares a common interest in placing the body at the centre of empirical and theoretical investigation. It often does so in ways that see the body as a construct, an unfinished biological and social project and an object of domination (see Shilling, 1993 and 2007). In this section I compare two key theorists in the field to assess their potential contribution to my study. These theorists are Foucault and Goffman.

Foucault is concerned with how power works on the body (e.g., 1973 and 1979). He argues that discourses – forms of meaning often expressed through language – work on the body to shape its existence and the way it is seen to exist. The operation of discourses requires the exercise of power, and Foucault argues that the modern body needs to be understood through the discourses and forms of power that produce it. He says that new forms of power arose with modernity; rather than being concerned with the control of anonymous individuals, the state became concerned to manage differentiated populations. In particular it needed to rule over a population healthy enough to work, reproduce and fight in battle. This need initiated new forms of surveillance and

regulation to discipline the body. Schools, prisons and hospitals can be seen as modern institutions enabling the management and surveillance of large numbers of bodies in one physical space, whilst medical examinations can be seen to generate detailed descriptions of bodies under observation. As well as controlling bodies externally, surveillance practices also encourage individuals to observe and monitor their own bodies in the belief that it is in their own interests. Obese individuals engaging in diet and exercise regimes can be seen to control their own bodies in a way that corresponds with state interests to maintain a healthy population. Individuals who avoid describing their obese bodies in medical terms can be seen to resist these discourses (see Throsby, 2007 above), with the political model of bodyweight existing as an overt form of resistance.

Turner (1982 and 1983), a key theorist within the sociology of the body, directly connects Foucault's interest in surveillance power to food in a discussion of discourses of diet management in capitalist societies. Turner combines Foucault's emphasis on institutional practices as forms of control with Weber's interest in rationalisation (e.g., Weber, 1958). He tracks a change from published 17th and 18th century treatises on diet which were aimed at the aristocracy and were religious in tone, to 19th century publications which outlined the proper diet of the working classes and employed moral terminology of hygiene, balance and control. Turner states that these morals invoked the capitalist concerns embodying the era: urban management, industrial efficiency and economics. A key question was: how much (or how little) could a worker be fed and still produce maximum output? These concerns led to the development of specific diet-based forms of body management such as diet instructions, food charts and exercise manuals. According

to Turner, "[c]ontemporary anxieties about obesity and dieting, slimming and anorexia, eating and allergy are part of the extension of rational calculation over the body and the employment of science in the apparatus of social control." (1982: p. 267).

Whilst Foucault focuses on how the body is produced, Goffman's interest lies in what it does. Goffman's contribution to the sociology of the body comes in his micro sociological analyses of face-to-face encounters (e.g., 1956; 1963; 1983b). He tells us that interactions between individuals are central to the conduct of everyday life and that the body plays a key role in them. Firstly, body practices such as eye contact and gesture are crucial to the flow of the encounter since "our appearance and manner provide evidence of our statuses and relationships … [and] allow others to glean our immediate intent and purpose" (1983b:p. 3). Without these bodily cues we may not be able to secure the engagement of others in interaction or ensure the continuation of the encounter.

Furthermore, there is a normative role for the body in social encounters. Just as collective expectations and norms exist about how individuals should present and conduct themselves in interaction, so they also exist about how the body should appear and behave. The individual needs to exert routine control over his/her own body when interacting to meet these expectations and therefore demonstrate competence as a social actor. If these collective norms are regarded as having been breached, this can lead to tensions which stigmatise, or devalue, the affected individual. The body is one source of this public norm-breaking in the form of "abominations of the body – the various physical deformities", such as attributes, blemishes and disabilities (1963: p. 4). Deformities of the body can be seen to provide clues

about 'inconsistencies of character'. They do so by betraying a discrepancy between the normative expectations of how an individual should be and act (virtual social identity) and the actual attributes and behaviours that person displays (actual social identity). In some cases the discrepancy can be hidden (e.g., baldness covered up with headwear, a colostomy bag hidden by clothing) and the individual can 'pass' as normal, avoiding interactional difficulties. In other cases the discrepancy is not or cannot be hidden and the subsequent behaviours of others present in the interaction may undermine the self and social identity of the stigmatised individual. "The attitudes we normals have towards a person with a stigma, and the actions we take in regard to him, are well known…we exercise varieties of discrimination, through which we effectively, if often unthinkingly, reduce his life chances." (1963: p. 4). As a physically large symptom of 'illness', the obese body is always visible in face-to-face encounters. Furthermore, as a possible symbol of greed and lack of willpower it can be seen to betray a negative actual social identity. This combination suggests that obesity may be viewed as a form of (moral) disablement, stigmatising the individual. The individual is then required to manage his/her bodily stigma in dealings with others, including in medical consultations.

Goffman provides a means to theorise a role for the body in interaction. He indicates that the body is key to maintaining the (smooth) flow of interaction and shows how collective ideas about a morally appropriate body may be evident in social encounters. Goffman's micro level focus and interest in interactions enable a view of the body as an actual material object that plays a role in interaction and are therefore directly relevant to my research interests. Undoubtedly, Foucault raises valuable points about the surveillance interests of medicine and the

supervision of the body but his work is less relevant here as he does not provide a means to conceptualise active bodies. Foucault depicts the body as somewhat abstract, a mere product of discourse, and appears uninterested in how people work on and use their bodies in practice. By contrast, Goffman emphasises agency and active bodies and offers insights into their importance in medical encounters. As shown in the next chapter and the final section of this one, Goffman's thought plays a crucial role in this study.

So far in this chapter I have reviewed social scientific literature on obesity, food and the body. This literature has suggested a number of themes that may be evident in discussions of obesity and indicate relevant role for the body in talk. In the final part of the chapter I discuss the sociology of medical interactions. This provides further themes of interest and further suggests the benefit of observational methods.

2.4: The sociology of medical interactions

This sociology of medical interactions investigates the ways practitioners and patients interact in variety of healthcare contexts. It encompasses a large body of work and a range of theoretical and methodological approaches. Rather than attempting to characterise the entire field, I focus in this section on one particular area of it. This area mostly concerns work conducted in the UK in the 1970s and 1980s involving the observation of medical consultations. As I discuss below, these observations suggest that features of interaction exist across medical encounters, regardless of changes in actor. Furthermore, it

adds that the discussion of 'lifestyle' issues can have negative implications settings for the interaction.

"[H]ere are over a thousand separate occasions on which parents met doctors and met them in all kinds of different circumstances and yet the manner of their meeting, the ceremonial order of the occasion was pretty much the same no matter how other things might vary." (Strong, 1979: pp. ix-x)

The 1970s and 1980s saw a "fashion…for collecting naturally occurring data" (Silverman, 1987: p. 6), leading to a growth in the use of ethnographic methods in medical sociology. The direct observation of medical consultations avoided reliance on reports of action from interview and survey respondents and the focus of study moved away from how people feel about medical consultations to what they do during them. The period was also characterised by interest in power relations between practitioners and patients, which was sometimes theorised as 'medical dominance'. For example, Freidson (1970) wrote about the profession's freedom from lay evaluation and control and its ability to determine what is labelled as 'illness'. His ideas were taken up in various observational studies, such as Bloor's (1976) investigation of routine practices in paediatric Ear Nose and Throat consultations and Oakley's (1980) work on hospital obstetric encounters. These types of study tended to emphasise the structurally dominant role of the practitioner and the passive role of the patient, unable to make much impact on decisions about his/her own treatment. However, an alternative view emphasised that patients have their own resources which they can use in medical interactions. This position is explicitly taken up by the first of two studies I focus on in depth. Strong argues

for "a more balanced view" (1979: p. 205) of power relations between practitioners and patients. He states that medical dominance coexists with 'medical gentility', which promotes an active role for the rational patient.

Strong conducted an observational study of more than 1000 paediatric consultations, mostly in the setting of a Scottish NHS city hospital, but with a smaller number in an American hospital. He used his observational data to argue that consultations tend to follow the same form, despite differences in the individuals involved. He added that this form can be generalised to many other medical encounters, including those between adult patients and practitioners.

Strong saw medical consultations as social occasions, distinct from everyday encounters and similar to ceremonies and rituals because they have their own special sets of rules. In order to study them, he turned to the work of Goffman, "the leading analyst of everyday ritual" (Strong, 1979: p. 10), and incorporated his ideas on frames (Goffman, 1975). Frames define specific situations. They have their own special meaning and language and shape the conduct of human life. This is evident in various encounters that are repeated again and again and tend to occur in a similar fashion, despite changes in social actor. Medical consultations are one such encounter, occurring in an institutionalised frame. Strong initially argued that Goffman's work was unable to accommodate multiple frames or individual roles and added his own concept of role formats[4]. These are "routinized, culturally

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[4] Strong later abandoned the term 'role format' and reverted to 'frame' following the publication of Goffman's book, "Frame Analysis". Cf Dingwall, Eekelaar and Murray (1983) Chapter 2, p. 248, footnote 2.

available solutions which members 'use' to solve whatever problems they have at hand" (Strong, 1979: p. 13). They provide a framework for individuals on how to act in certain situations. The concept of role formats does not suggest that behaviour is determined, but it does recognise that individual actions may be constrained by context.

Applying this theoretical framework to his data, Strong argues that the consultations he observed were mostly framed by a bureaucratic format. This format is characterised by four major features, the first three of which are: an idealised image of the parents of the child patient who were assumed to be competent regardless of their actual characteristics; an assumed competence and expertise of medical staff (with parents/patients assumed to be ignorant and incompetent); and an overt and idealised alliance between doctor and parent in which decisions were discussed rather than imposed. However, this alliance is an asymmetric one; the fourth feature of the bureaucratic format is that medical control is systematic and almost unquestioned, leaving parents excluded and controlled.

The combination of the four features means that interactions in consultations are controlled by the practitioner but conducted in an extremely polite manner in which parents are assumed to be rational, competent and properly motivated, and medicine is assumed to deal solely with natural phenomena to the exclusion of moral character assessments. This does not mean that normative issues are irrelevant or absent, but rather that "doctors [go] to great lengths to conceal the moral basis of their work and to transform medical practice into a neutral, 'scientific' affair that dealt purely with natural happenings." (p. 212). They are able to do so because of their ability to control and limit

topics of talk in consultations. Although parents have their own interactional resources – to express disagreement, introduce alternative viewpoints etc – they are also constrained by the institutional context. In addition, Strong argued that interactions in the bureaucratic frame are collaboratively achieved through avoidance, or what Goffman (1956) terms, the 'rule of irrelevance'. Any features of the format that do not fit – emotions, attitudes, alternative actions – are not referred to. "We make a world and behave, for the moment, as if we could not see the wider worlds from which it is made and which it is situated." (Strong, 1979: p. 39). This may be achieved with varying levels of ease, and in some cases 'active nullification' is required to demonstrate that matters are not relevant. With their ability to control topics of talk in the bureaucratic frame, doctors are better able than parents/patients to engage in active nullification.

Strong argues that despite the availability and occasional incidence of alternative role formats, the vast majority of consultations (in NHS settings at least) follow this bureaucratic framework. Its existence and prevalence is reinforced through its reproduction in subsequent medical encounters. Strong also argues that the parent-practitioner encounters he observed could be generalised to patient-practitioner ones because children were routinely edged out of consultations with parents taking their place as patients. Therefore Strong claims "quite good grounds for suggesting that the bureaucratic format or something like it, is a far more widespread phenomenon." (p. 194). In support of this view, he points to the findings of existing observational studies of primary care, such as those by Stimson and Webb (1975), and Byrne and Long (1976).

Strong's characterisation of the bureaucratic format offers a way to conceptualise consultations for obesity. It stresses that despite the asymmetrical relationship between doctors and patients, consultations are achieved collaboratively through the interactional work of participants. The bureaucratic format suggests a way in which talk in weight loss consultations might take shape – impersonal, polite and based on discussion of organic factors. Any behaviours or attitudes that do not fit these characteristics, such as cultural understandings of food and the body, may be treated as irrelevant. This may be achieved straightforwardly and routinely in practitioner patient interactions, or alternatively it may require active nullification, possibly initiated by the practitioner. However, if we accept the argument in some of the above literature that medical descriptions of obesity contain non-neutral assumptions, we may query how far practitioners are able to conceal the moral element of their work in the context of weight loss consultations.

The second work I discuss here takes up and extends the themes of the first. In his study, "Communication and medical practice: Social relations in the clinic" (1987), Silverman reports on a collection of empirical studies of communication in health care. These studies were carried out between 1976 and 1985 and involved observation of doctor-patient/doctor-parent interactions in a variety of settings. Silverman adopts Strong's concept of the ceremonial order of the clinic as a framework for understanding these encounters. He agrees that (NHS) consultations occur within a bureaucratic frame, stating "our observation of more than 1000 outpatient encounters wholly accords with Strong's findings about the appeal to reason and politeness" (p. 30). Silverman also acknowledges that the bureaucratic format

provides a means to limit professional dominance, but draws on Foucault (1973) to claim the rise of a new clinical discourse inaccessible to the patient.

In a chapter titled "Policing the lying patient: Surveillance and self-regulation in consultations with adolescent diabetics" (1987: pp. 205-232), Silverman highlights the tensions inherent to a 'humanistic' approach to medical care and their consequences for the bureaucratic format. He argues that the assumption of patient rationality, or 'theoreticity', both emancipates and pressurises the patient. Silverman collected observational data in two clinics treating teenage diabetics, one for 'problem' patients with poor treatment histories and one for 'routine' cases. These teenage patients had diabetes mellitus, a chronic condition that requires life-long administration of tests and injections as well as diet control. Silverman notes that this need for patient self-administration "creates a special problem in itself for it demands a degree of activity from the patient that is very different from the common model of the passive patient and active physician" (p. 205). Consequently, he observed a tension between the need for medical control demanded by the bureaucratic frame and the need for patient autonomy demanded by diabetes care. This tension sometimes led to the bureaucratic format being breached by the doctor, particularly in consultations at the 'problem' clinic where – in the medical view - patients were less successful in achieving 'control' of their condition.

Silverman observes that a number of interactional features in the clinic reveal "the double-edged nature of appeals to patient autonomy and responsibility" (p. 211). The first feature is that the patient is granted 'theoreticity', the capacity for rational thought and the ability to choose

between alternative courses of action. Once the patient is granted theoreticity, he/she is defined as an active decision maker and gains individual autonomy. However, the second feature is that the patient also comes to be regarded as morally responsible for her/his own actions. A consequence of this can be practitioner comments of praise or censure. Criticisms can produce feelings of guilt in the patient and construct the consultation as "a kind of trial for the patient in which she is to be held accountable for her actions" (p. 215). Other occasional features were (attempted) practitioner-initiated discussions of family relations and patient psychology, both breaches of the bureaucratic format. Finally, negotiations about treatment behaviours were initiated in attempt to balance between the tensions of autonomy and responsibility and therefore provide a solution for both practitioner and patient.

Silverman argues that these interactional features are connected to the condition being discussed. There is something particular about diabetes and its medical care that means consultations sometimes diverge from the impersonal and polite form normally observed in clinical settings. It also means that 'non-medical' topics such as everyday behaviours and lifestyle issues are brought into the talk. This is due to the emphasis placed on the active involvement of the patient in dealing with a chronic condition, with the result that, "often sometimes reluctantly, doctors feel compelled to get involved in what for them are murky, intractable psychological and social issues" (p. 207). Silverman adds that the patient is not just able to become involved and make active choices; he/she is actually compelled to do so or risk censure. This both emancipates and constrains the patient, who must report his/her acts, even if it means exposing 'wrong' behaviour. In the Foucauldian sense,

this acts as a form of internal surveillance, in which the individual performs the act of power over him/herself.

In a study of GP consultations, Pilnick and Coleman (2003) similarly note that difficulties in interaction can occur when practitioners connect a patient's health status to a lifestyle issue: in this case smoking. Pilnick and Coleman found that when doctors connect a patient's presenting health problem to his/her smoking behaviour, the patient sometimes responds with talk that rejects the suggested link. For example, they might use their talk to dissociate their current health complaint from their smoking habit, directly contradict the doctor's suggestion or assert that smoking is not relevant to the current consultations. These kinds of statements can be seen as forms of explicit resistance and to a certain extent can be seen as a rejection of the possibility that smoking is morally as well as medically 'wrong' behaviour.

Pilnick and Coleman invoke the sick role to suggest that patients' resistance to talking about smoking as a negative health behaviour also functions to resist them being labelled as indulging in behaviours that cause them to be responsible for their own ill health, and by refusing to stop those behaviours, as not making appropriate efforts to become well. They also note that this kind of resistant talk is rarely observed in medical consultations about other health topics. This suggests that smoking may be another lifestyle associated with medical talk which breaches the overtly neutral bureaucratic frame. Although this study can be seen to support Silverman's arguments about doctors raising certain topics that may appear to censure the patient, its focus on

resistance also demonstrates that patients can play a more active role than the Foucauldian perspective of power allows.

As with the Mycroft, and Sneijder, te Molder and Wiggins studies described above, Pilnick and Coleman employ a conversation analytic approach. This enables them to discuss in detail how the talk in the consultation is achieved collaboratively and pay attention to interactional devices that both doctors and patients employ to affect the outcome of the talk. A particular benefit of employing CA in a medical setting is that it describes how treatment is delivered through talk. Furthermore, in the case of lifestyle conditions such as smoking related illnesses and obesity, it also recognises that talk forms part of treatment itself, in the form of advice-giving and descriptions of behaviour.

The studies by Silverman, and Pilnick and Coleman suggest a number of points relevant to my own study. Obesity and diabetes are similar in medical terms since they are both long-term conditions that require the active participation of patients for successful treatment. Like diabetes and smoking cessation, obesity is also associated (by the medical profession) with low rates of treatment success and an inability to rely on patients to report their behaviours with accuracy, setting up possible practitioner diversions from bureaucratic format encounters. The positioning of the patient as rational and responsible for success could lead to the introduction of moral elements to the interaction. This might include orientations to the moral model of body weight and negotiations between practitioners and patients to find a solution to points of disagreement. However, the capacity for patients to resist possible censure/medical attention also needs to be recognised.

The three studies discussed in this section also offer methodological insights relevant to my study. Firstly, by focusing on medical talk, they are able to acknowledge a condition as socially constructed whilst also recognising that it has empirically analysable consequences in social life. Furthermore, they indicate the benefit of collecting 'thick' data by observing consultations directly. Additionally, the recording and transcription of data (by Silverman, and Pilnick and Coleman) means that consultations can observed again and again, increasing the reliability of results (Peräkylä, 1997). Finally, the interactional focus of the studies, in particular the CA study conducted by Pilnick and Coleman, emphasises the active role of all interactants and moves away from attempts to understand participants' perspectives of medical encounters towards an empirical investigation of what they do during them.

2.5: Discussion

In this chapter I have discussed social scientific literature relevant to obesity and medical interactions. I began by discussing work that relates directly to the condition, noting a contrast between a sociology 'in' obesity which uses official definitions and statistics as the basis for research and a sociology 'of' obesity which uses those definitions and statistics as an object for analysis. I then considered a small amount of work on obesity-related medicine before assessing the potential contribution to the sociology of food and the sociology of the body. Finally, I considered some key studies within the sociology of medical interactions. These literatures reveal a number of points of interest for my study. They suggest themes that might be significant in my analysis

indicate opportunities for future research and point to a methodological framework for the research of medical interactions.

Existing social scientific work on obesity can contribute to my study in a number of ways. Crucially, this work opens up obesity as a topic for sociological analysis and demonstrates that the discipline can add to knowledge about the condition and offer findings of relevance to policy. It also raises themes of interest for my research by suggesting that social factors may influence which types of people become obese and subsequently receive medical attention. Furthermore, it emphasises that lay people may express attitudes towards obesity that differ from medical descriptions of it and may correspond with normative concerns discussed in the previous chapter. Studies of obesity-related medicine suggest that the condition may be little discussed, plus that patients may again express (moral) attitudes that differ from or even resist medical views of obesity. These points raise the possibility that competing attitudes may be expressed during discussions about obesity between practitioners and patients, and that they may be a source of interactional tension. The sociology of food adds to this by treating food and eating as inherently social phenomena, influenced by collective norms and indicating that talk about them frequently invokes normative issues of responsibility and control. Additionally, Goffman's contribution to the sociology of the body suggests that bodies play a key role in interaction, both in ensuring its maintenance and demonstrating the normative status of the individual to others present.

This sociological work offers a useful contribution to my research into talk during obesity-related medicine. However, it also has a number of absences. There is an absence of work directly investigating medical

treatments for obesity and in particular looking at the talk that occurs during them. Furthermore, with the exception of the conversation analytic studies discussed at various points in this chapter, there is also a lack of investigation into talk about obesity and issues connected to it. It cannot be assumed that the attitudes observed in interview and text-based studies will persist in interaction or that they will be present in medical discussions and have an effect on their outcomes. This is a key empirical omission since medical treatment is a major part of the obesity phenomenon. Treatment is advocated as a solution to the 'problem' and, as the government guidance discussed in the previous chapter indicates, talk is presented as a central means through which the 'cure' can be delivered. By overcoming these absences my study can make a unique contribution to the field whilst also offering a commentary on current guidance.

The absence of work directly observing medical treatments is a methodological as well as content-based omission. The studies discussed in the sociology of medical interaction sections of this chapter indicate the benefits that observational, interactional approaches can bring to analysis. They indicate that talk is central to medical encounters and that it is an activity carried out by all those present. Therefore medical consultations can be seen as the joint accomplishment of practitioners and patients. Furthermore, these studies suggest that procedures of talk are relatively stable, persisting despite changes in the personal and demographic characteristics of those present. The studies by Silverman, and Pilnick and Coleman add that medical discussions of certain lifestyle-related conditions can involve unusually tense interactions in which normative concerns about appropriate behaviour may be invoked by both practitioners and

patients. These findings also connect to the analyses of interactions about food conducted by Mycroft, and Sneijder, te Molder and Wiggins, which reveal how moral issues surrounding eating are made visible in talk. These studies offer a methodological framework to analyse whether similar interactional patterns occur when practitioners and patients discuss obesity – a condition which existing literature suggests is also related to normative concerns about appropriate behaviour and personal efforts to ensure health. In particular, they indicate the benefit of employing conversation analysis as a means to investigate talk as a social and moral activity. This is developed further in the following chapter.

Chapter 3: Methodology

3.1: Introduction

This chapter sets out the methodological stance of my study. In the preceding chapters, I have shown that medical treatments for obesity are delivered by and through talk, meaning that in the healthcare setting interactions between practitioner and patient are a central area for analysis. I now present conversation analysis (CA) as the appropriate approach to analyse these interactions. I begin the chapter by discussing its theoretical underpinnings in the work of Goffman and Garfinkel, highlighting the central concepts of the interaction order and practical reasoning. I then discuss conversation analysis as theory and practice. I detail the key assumptions of CA, its approach to analysis, its role in analysing institutional encounters such medical consultations and some criticisms of, and debates about, its methodology. As a naturalistic, observational approach that sees talk as social action, CA offers a distinctive and valid means to investigate interactions in medical encounters.

3.2: Theoretical underpinnings: Goffman and Garfinkel

When considering the methodology of conversation analysis it is essential to discuss the theoretical contributions of Erving Goffman and Harold Garfinkel. Despite taking different ontological stances both contribute to our understanding of everyday interactions and orderliness in social life. Their insights on the interaction order and practical reasoning form the foundations of conversation analysis.

3.2.1: Erving Goffman

Goffman is a hugely influential figure in modern sociology. As shown in the previous chapter his thought has been taken up in various fields, including the sociology of the body and the sociology of medical interactions. His contribution to the development of conversation analysis comes through his interest in face-to-face interactions as a substantive social domain open to analysis. Goffman tells us that "most of the world's work gets done" through social interaction (1979: p. 6). Through his discussions of life as theatre (1956), game (1966) and ritual (1967) he tells us that social encounters, and therefore social life, are intrinsically fragile. Individuals may subvert conventions of behaviour to their own advantage or a discrepancy between their 'real' and 'social' selves may be revealed to their disadvantage and embarrassment. Despite this, order tends to prevail and is quickly restored if broken. This is because the behaviours that maintain order are often socially determined and adhering to them rewards individuals with "the profitability of appearing always in a steady moral light" (1956: p. 251). Goffman therefore perceives a strong normative element in interaction.

In one of his early works, "On face-work: An analysis of ritual elements in social interaction" (1955 and reprinted in 1969), Goffman outlines how interaction is bound up with issues of 'face'. He defines 'face' as "the positive social value a person effectively claims for himself by the line others assume he has taken during a particular contact." (1969: p.3). The 'line' refers to the verbal and non-verbal (e.g., gesture etc) practices adopted by an individual to portray his/her version of a situation, event, character etc. Crucially, it is others, not ourselves,

who evaluate this line; it may or may not be the same line that we (consciously or otherwise) intend to project. Face is something others assume to have been portrayed by the actor and is therefore a product of interaction.

Through his concept of 'face-work' Goffman describes the "actions taken by a person to make whatever he is doing consistent with face" (1969: p. 9). In Individuals work to maintain face and 'save' it when it is threatened. This may be done through the avoidance of situations/people that may threaten face or through the use of corrective practices when a problem occurs. The maintenance of face is particularly resonant in face-to-face encounters. It is a "human tendency to use signs and symbols" (1969: p. 26) and this means that issues of social worth may be tied up in very small acts – gestures, words, tone of voice etc – to be witnessed and judged by others. Therefore co-present individuals are always required to show attention to the way they conduct themselves and to the conduct of others. However maintenance of face is rarely the object of an interaction. Instead the different tasks carried out in interaction – greetings, offers, acceptances etc – are conducted in ways consistent with the maintenance of face. This is because the practices, procedures and conventions of interaction have a strong social and ritual element.

In some of his later works Goffman sets out more explicitly the ways in which face-to-face encounters can be understood, and analysed, as a substantive social domain. By this time Sacks and Schegloff were already developing the conversation analytic approach (see below and Schegloff, 1992) and these works influence CA whilst also debating with it to some extent. In his 1982 American Sociological Association

conference presidential address (1983a: p. 2) Goffman argues that interactions "in which two or more individuals are physically in one another's presence" (and to a lesser extent phone conversations and letters) take place in the 'interaction order'. This is a domain of activity with its own internal conventions and mechanisms. It has a distinctive form that is not dependant on external institutions, such as the state, though it may be influenced by them. The interaction order provides the rules, rights, obligations and (moral) motivations which shape and constrain social encounters. Consequently, these encounters tend to unfold in an orderly fashion across space and time and the interaction order itself is able to resist external threats to its existence (Rawls, 1987).

In Felicity's Condition (1983b), Goffman explores some of the presuppositions that contribute to the orderliness of the interaction order. He argues that "writing or saying makes sense only if the actor intends a meeting of the minds" (p. 2) and that therefore a range of social presuppositions are embedded in language use. Smooth discourse depends not on the truth-value of statements but on a shared understanding of the "presuppositions it would be reasonable to have in the circumstances" in which specific encounters occur (p. 27). For example:

A: What did you think of the movie?
B: I didn't like it.

In this exchange, speaker A presupposes that speaker B will reasonably know which film is being referred to even though it is not mentioned by name. Perhaps A knows about B's recent activities or as A speaks both

are leaving the cinema having just watched the film. Likewise, B presupposes that A will understand that 'it' also refers to the film because A will have a reasonable awareness of substitution terms in language and will be able to deduce that, unless marked as doing otherwise, talk following a question will logically provide an answer to that question. These considerations may appear to be concerned only with the mechanics of talk, but once again Goffman sees a key moral element. It is partly through their language use that we judge others and decide whether or not they are 'normal', creditable social beings. The standard of effective language use, 'Felicity's condition' itself, is "any arrangement which leads us to judge an individual's verbal acts to be not a manifestation of strangeness." (p. 27). In this paper Goffman marks out several areas of disagreement (and agreement) with conversation analysis (as well as socio-linguistics and pragmatics) and it is important not to assume that CA has taken up his ideas unproblematically (Schegloff, 1988). However, Goffman's assertion that the interaction order exists and is a domain open to sociological study proved central to the development of the discipline.

3.2.2: Harold Garfinkel

Like Goffman, Garfinkel sees daily, taken-for-granted practices as central to social order. However, where Goffman talks about following 'the rules of the game' Garfinkel's theory is more action-centred and emphasises the role of practical reasoning. Garfinkel started his career at a time when the theories of Parsons and Merton were dominant and researchers "worshipped in the computer room" (Garfinkel, 2002: p. 12), using quantitative methods to find variables explaining social life. Despite studying for his PhD under the supervision of Parsons,

Garfinkel rejected Parsonian theory with its emphasis on structure, the social system and macro level generalisations. Instead, he argued for the importance of empirical description and insisted that sociology should produce detailed descriptions rather than relying on conceptual categories. Whereas Parsons saw social order as a factual order with external and objective rules constraining individual behaviours, Garfinkel sees actors as more active than this. Actors use rules rather than follow them and use them in an ad-hoc rather than pre-determined way. Constraints on action do exist but they are part of action itself rather than coming from the external world. In taking this position Garfinkel also inverts Durkheim's (1938) conception of social facts. Garfinkel agrees with Durkheim that the task of sociology is to study social facts. Durkheim saw these as group practices which are collectively understood and internalised by the individual. They always constrain what the individual normatively can and cannot do. In contrast, Garfinkel sees social facts as human accomplishments (2002), produced by and through action.

Another major influence on Garfinkel's thought comes from phenomenology, in particular the work of Schutz (1962). He follows the assumption that the world does not exist, or cannot be known to exist beyond our perceptions of its existence. Since the world is very complex, as individuals we cannot experience or process it all. Therefore we categorise phenomena in order to make sense of them. As a basic act of consciousness we build up 'typifications', abstract models of what is a 'typical' female, 'typical' home, 'typical' middle class person and so on. Typifications are important forms of taken-for-granted knowledge and through them we can understand and act in the world. These underpinnings demonstrate that in Garfinkel's thought the

individual is not separate from society and that order is not external to action. Garfinkel adds an interest in linguistic philosophy, stating that we need language as an essential part of interpersonal activity. Order is a product of action and language is central to action.

The most influential of Garfinkel's works, "Studies in Ethnomethodology" (1967) brings together these influences and establishes ethnomethodology as a radical new form of sociology. This collection of papers written over 12 years includes descriptions of his breaching experiments as well as the 'jury study' that gives ethnomethodology its name. Garfinkel studied the way jurors carried out their duty to make legal decisions and noted that in their deliberations they expressed concern with the methods of their own decision making. They spoke of the need to be clear about what could be counted on as 'fact', 'opinion' 'evidence' and so on and relied on others to use the same distinctions. Significantly, Garfinkel noted that the jurors were not using some special setting-unique logic during these deliberations; in fact they relied on 'common-sense' knowledge and referred to things that 'anyone could see' (Heritage, 1984b). This led Garfinkel to conclude that "a person is 90% juror before he comes near the court" (1976: p. 110).

Having identified the prevalence of shared common sense knowledge, Garfinkel set out to investigate how it is used in daily life. 'Ethnomethodology' can be broken down into parts: 'ethno' refers to people and their common sense knowledge; 'methodology' refers to the practices they use to make sense of the world; and 'ology' is its study. So ethnomethodology is the study of people's methods, through which they make sense of the world and create orderliness. Garfinkel defines

it more expansively as: "the investigation of the rational properties of indexical expressions and other practical actions as contingent ongoing accomplishments of organized artful practices of everyday life" (as above: p. 11). His term 'indexical expressions' refers to a key concept within ethnomethodology, relating to language and meaning. According to Garfinkel, there is no final, objective meaning in talk. Instead, meaning is dependant on context. As one of his breaching experiments shows, we can go on asking 'what do you mean?' indefinitely and never come to a final point of shared, definite meaning. However, in most daily interactions this lack of set meanings does not create trouble. Instead we create and maintain through reference to other talk, such as immediately prior utterances, and to the context in which words are spoken. This is indexicality and it enables us to hear what is meant in talk rather than just what is said.

Connected to this is the concept of reflexivity. As noted above, we deal with the huge variety of phenomena in every day life by using typifications, or general patterns of understanding, to make sense of individual phenomena we come across. We draw on an abstract layer of typifications to give sense to actual experiences. It is through this reflexivity that we are able to give meaning to the talk that we hear. In turn these actual experiences feed back into our typfications. One other central concept is accountability. Garfinkel says that when we act, we design our actions so that their sense is immediately and straightforwardly understandable to others. So when we greet others, issue an invitation or make an apology, we employ certain words, facial expressions, gestures and so on that make clear what it is we are doing. These accountability actions are not in addition to the greeting, apology and so on, they are inherent to it. The act of doing something

is inseparable from designing that action to demonstrate what is being done. When we act we do something and simultaneously account for ourselves as doing that thing. Accountability therefore introduces a moral element into action (but rather differently to Goffman's formulation). The concepts of indexicality, reflexivity and accountability enable us to understand how actors make the world meaningful through common-sense reasoning and accomplish order as a product of action. Ethnomethodology's task is to describe and analyse these common-sense practices. The epistemics of conversation analysis take much from Garfinkel and CA can be seen as founded in ethnomethodology.

3.3: Conversation Analysis as theory

"So the work I am doing is about talk. It is about the details of talk. In some sense it is about how conversation works. The specific aim is, in the first instance, to see whether actual single events are studiable and how they might be studiable, and then what an explanation of them would look like". (Sacks 1967 fall lecture, quoted in Atkinson and Heritage, 1984: p. 26)

The influence of Goffman and Garfinkel's thought is easily identifiable in conversation analytic theory. Harvey Sacks and Emanuel Schegloff developed the 'turn-taking' model (with Gail Jefferson) familiar to CA and both studied with Goffman and collaborated with Garfinkel during the 1960s and 1970s. They shared with both theorists an interest in linguistic philosophy and empirical sociology (Silverman, 1998). As Schegloff (1992) and Drew (2005) document, conversation analysis itself grew out of a much broader study undertaken by Sacks and

Schegloff in the 1960s on the possibility of a natural, observational science of social action. During the study, Sacks and Schegloff turned to recordings of telephone calls made to suicide call centre. They noted the analytic benefits of being able to observe the content of recorded data again and again. This led to an interest in the content of the calls: conversation itself.

CA developed as an approach enabling the study of 'single events' of talk. Sacks outlined his major methodological concerns during his recorded lectures at the University of California (1992 and Atkinson and Heritage, 1984: pp. 21-27). Following Goffman, he positions interaction as a domain of research in its own right and perceives the practice of conversation as regular and ordered. However, unlike Goffman, who in his analyses of talk in Felicity's Condition and elsewhere used made-up examples, Sacks argues for the importance of 'real' data rather than "hypothetical, or hypothetical-typical versions of the world" (Atkinson and Heritage, 1984: p. 25). Sociology should aim to be naturalistic and observational and as such its key method is to record actual events and analyse them. The aim of that analysis is to identify what particular instances can tell us about general patterns of interaction. Emphasis is therefore placed on the 'machinery' of interaction and the practices through which talk unfolds. These practices are seen as universal and normatively organised. Therefore analysis of talk tells us much about the achievement of social solidarity in daily life (Heritage, 1994).

In a recent paper on "Conversation Analysis as Social Theory" Heritage (2008) outlines the two major theoretical assumptions of CA. The first is that CA is the structural analysis of action in talk. It considers talk as social action and is concerned with patterns recurring across talk rather

than with variations of talk to be found in different dialects, accents and so on. The orderly, procedural unfolding of interaction can be observed without reference to the subjective motivations, psychological characteristics or social statuses of individual actors. Unlike some approaches to discourse, CA does not assume that a speaker's gender, class or current situation will necessarily dictate the way talk proceeds. Instead, interactional practices may be the "medium through which these sociological and psychological characteristics manifest themselves" (p. 7).

The second assumption states that 'ordinary conversation' is the "fundamental domain for analysis" (Heritage, 2008: p. 9). Ordinary conversation refers to everyday talk between peers rather than the kind of institutional talk that occurs in courtrooms, schools, hospitals and so on, where interactions may be organised in explicit ways. Whilst institutional organisations are subject to change over time, ordinary conversation is more constant, so its analysis reveals fundamental interactional practices. These fundamental practices also form the basis of institutional talk, so that, whilst talk in a medical consultation may appear unique to the setting, it actually draws on conversational sequences well-established in everyday life (showing once again that the independence of the interaction order). This means that when analysing institutional encounters as specific forms of talk, it is essential to consider what is generic about the practices observed before attributing them to the particular tasks and roles of the setting. Following the same principle, analysts should also take care, when analysing any data, to consider how the practices observed in the data may be explained by generic devices before turning to external explanations such as class, gender and so on (Schegloff, 1997).

3.4: Conversation Analysis as practice

A CA study begins with data collection. Following Sacks' call for a naturalistic, observational social science, these data must be naturally occurring and should be recorded to enable repeated observation. The data are then transcribed to record the utterances spoken plus the features of its delivery. The definitive format for CA transcription was devised by Gail Jefferson (1984), who developed a series of markings to convey features such as word stress, intonation and length of silences between talk. As the CA project has grown, some other markings have been added. The transcription format followed in this study is set out by Heritage and Maynard (2006c) and is reproduced in appendix A. Transcription enables a detailed presentation of the interactions occurring in the data that extends far beyond 'just' the words that are spoken. A simple comparison demonstrates the analytic value of this.

Extract 1: (from Hunt and Hillsdon, 1996: p. 63)

> P: Perhaps we can start then, by you telling me what you've
>   Noticed about your weight. How has it changed over time?
> C: Well I was trim when I got married, then with having the
>   three children it rocketed. I suppose I ate for comfort
>   really-
>   they used to drive me mad when they were little! About 5
>   ago I did lose a bit, then put it all back on. Last year I had
>   another real go and got it right down to 13 stone. But look
>   me now, almost back to square one. I don't seem to have
>   the will power.

P: So you gained weight with having the children and while

        they were young. More recently you have successfully lost

        some weight, twice. But both times it's gone back on.

C: Yes… but I'm determined not to give up this time.

Extract 2: (originally from Gill and Maynard 2006, cited in Halkowski and Gill, 2008:p. 7. Note altered line numbering.)


```
1.    Dr:    You mention some easy bru̲i̲sing? An

2.           bleeding? Fatigue?

3.    Pt:    Yea̲::h̲. I-an the- an: that you know: has

4.           been (.) most recently that I have the

5.           fatigue. But I guess: you know: you're

6.           (just not supposed ta 2.5) °keephh° (0.5)

7.           °burning the candle° at both ends all the

8.           ti(h)me(h) (h) [(h)

9.    Dr:                   [.hh Ah:: well-?

10.   Pt:    .HHH

11.   Dr:    We'll (0.7) look inta

12.          tha[t.=See if there's

13.   Pt:       [Y'know::

14.          (.)

15.   Dr:    might be any underlying causes for

16.          fatigue.
```


Extract 1 is a (somewhat obviously) made-up dialogue taken from a guide for health and fitness professionals on how to encourage clients to lose weight. Extract 2 is from a conversation analytic study of talk between doctors and patients in primary care. With knowledge of the markings used on the CA transcript, it is clear that extract 2 far more

resembles actual talk than extract 1. We do not always talk in complete sentences, we do not speak fluently at all times and we do not always speak one at a time. Instead, as extract 2 shows, talk frequently involves grammatically incomplete utterances, hesitations, repeats and two or more people speaking at once (for a while at least). These are not merely pedantic observations; they are analytically valuable features. For example, noting where a speaker begins to talk in overlap, as in extract 2, lines 8 and 9 and 12 and 13, shows us what part of the previous talk the speaker is likely to have heard and be responding to. Similarly, whilst extract 1 glosses the way in which talk is delivered, with exclamation marks and dots, a CA transcript marks prosodic features such as volume and intonation and notes the length of pauses in tenths of a second. This in turn can provide evidence on the key words in an utterance, how its delivery may be hearable to others and the difficulty the speaker may have producing it. These and other features of delivery are treated as potentially relevant to the analysis and are therefore noted in the transcript.

The task of analysis is to identify patterns of interaction, describe them and explain their logic. Sacks tells us that this process begins by looking at the data in an "unmotivated way" (1984: p. 27). Analysis should be absent from any pre-set ideas of what patterns might be found or what type of interactional events to look for in the data. This is because if we set out to look for something particular, we risk missing something more interesting or important that is also there. However, research projects frequently do contain specific analytic objectives, meaning that this unmotivated approach is not always possible. Furthermore, established CA studies have pinpointed various themes of analytic value and uncovered interactional typical patterns -

of agreement, disagreement and so on - that we might expect to find in any piece of data. It seems logical to reference these studies and build further investigation on existing findings rather than to begin each piece of analysis with a 'blank slate'. So in this sense, the principle of unmotivated looking may not be practical or sensible. Nevertheless, as an ideal, it demonstrates the benefit of allowing themes to emerge inductively from the data.

Analysis itself looks at the data in detail to describe how talk unfolds in sequences of action. Although there is no single, 'standard' means of conducting conversation analysis, studies do tend to converge around similar practices. Firstly, analysis begins with the selection of one data extract – chosen through unmotivated looking or on the basis of pre-identified themes – which is then investigated in terms of four "analytically distinguished but interlocking 'organisations.'" (ten Have, 1999: p. 107). ten Have lists these as: turn-taking organisation; sequence organisation; repair organisation and the organisation of turn-construction/design.

3.4.1: Turn-taking organisation

A fundamental observation of interaction is that speakers take turns to talk. In a seminal paper Sacks, Schegloff and Jefferson (1974) outline the mechanics through which speakers exchange turns at talk and through which conversation – as opposed to speakers talking all at once – is accomplished. The length of a speaker's turn is not necessarily fixed and may vary from a single word to an extended period of talk. Talk is made up of units known as 'turn-constructional units' (TCUs). A TCU may be hearable as complete based on its

grammar, lexis, prosody or 'sense' in context. It can also be seen to perform some kind of action. So in extract 2, the doctor's turn in lines 1-2 can be heard as three TCU's, each performing the action of a question: 'You mention some easy bruising? An bleeding? Fatigue?' As interactants we monitor the talk we hear for TCUs, as the completion of each one provides a 'transition relevance place' in which speaker change can possibly occur. At each transition relevance place, turn allocation can proceed in a number of forms: the current speaker selects the next speaker (through gaze, content of the turn, naming the next speaker etc); the next speaker self-selects to talk; or the current speaker continues talking, producing further TCUs. The process is repeated again and again and the result is that transition between speakers occurs and tends to take only a 'beat' of silence, around 0.1 - 0.2 seconds, avoiding gaps or overlaps.

The system of turn-taking provides a means through which actors exercise their rights to talk. Its normative organisation is administered by the interactants themselves, who may make adjustments to restore normal turn-taking. For example, allocation of when speaker change occurs can be complex. Many overlaps, such as the doctor's turn in line 9 and that patient's turn in line 13 in extract 2, can be heard as anticipating the completion of a TCU and projecting a transition relevance place (Jefferson, 2004). But whilst overlaps are common, they tend not to last for long. Usually at least one speaker drops out of talk and this maintains the one-at-a-time norm (Sacks, Schegloff and Jefferson, 1974). Furthermore, where gaps between turns do occur, interactants may orient to some oncoming 'trouble' in the talk (see turn design and preference organisation, below).

3.4.2: Sequence organisation

A consideration of individual turns can inform us what actions speakers perform in their talk. However, actions do not occur alone; they follow other actions that have occurred before and project further ones to follow. As such talk needs to be considered in sequences. Sequence organisation is a fundamental part of conversation analytic investigation. Although they may extend over a very long number of turns, the most basic form of sequence is the 'adjacency pair'. This consists of a first pair part, such as a question, invitation, assessment, compliment etc, and a responsive second pair part, such as an answer, acceptance/rejection, agreement/disagreement, compliment receipt and so on. These two-part sequences are often expanded. The first speaker may produce a turn in third position which connects to the second speaker's turn in some way; for example a first speaker may reaffirm a compliment after a second speaker has modestly rejected it (Pomerantz, 1978). Additionally, a second speaker may insert a new sequence after the first pair part, for example by requesting clarification of something in that first turn (Schegloff, 2007). Adjacency pair sequences can also function as pre-sequences, which hearably prepare for another possible sequence. For example, the question 'Are you free tomorrow night?' is hearable as preparing for some kind of invitation to follow if the second speaker answers with an affirmative. This is a pre-invitation sequence. CA has also identified other kinds of pre-sequences such as pre-requests and pre-announcements (ten Have, 1999).

Sequences enable meaning to be constructed indexically through context. When producing a first pair part a speaker projects, or makes

'conditionally relevant', the action that the second pair part will perform. So in extract two, by producing a question the doctor makes relevant an answer from the patient. In producing the relevant next turn, the second speaker designs the turn to address the prior action and displays an understanding of that action. This relationship between turns is normative as well as mechanical. A next speaker is normatively required to produce a turn that in some way 'fits' the prior turn and may be sanctioned for not producing one.

3.4.3: Repair organisation

As mentioned above when comparing extracts 1 and 2, talk does not unfold in a smooth, untroubled fashion. Disruptions occur in the form of hesitations, abandoned talk and repeats, as well as displays that one speaker has not heard or understood what another has said. These kinds of trouble are dealt with through practices of repair.

CA analyses have identified a variety of practices that initiate the repair of an individual's talk (e.g., Jefferson, 1974; Schegloff, Jefferson and Sacks, 1977; Schegloff, 2000). These can be broadly divided into practices of self-initiated repair and other-initiated repair. Speakers initiate repair in their own turns at talk through practices such as cutting off in the middle of a word or phrase and elongating the end of a word. In extract 2, lines 3-4, 'Yea::h. I-an the– an: that you know: has been', the cut offs at the end of 'I' and 'the', plus the elongations at the end of 'an:' and 'know:' can all be heard as forms of repair initiation. The same speaker may then operate repair on the problematised talk in a variety of ways. These include reformulating the talk, repeating part of the talk with certain elements inserted or

deleted, or restarting the talk. In lines 3-4 the patient can be heard to restart the talk in 'an the', 'that you know' and finally 'has been'. In this extract the speaker self-repairs within a TCU but self-repair may also be initiated and operated in a transition relevance place or following another speaker's turn.

Repair organisation is designed to "respect the rights of speakers to say 'what they wish to say' and to own it." (Heritage, 2008: p. 14). This is seen in the ways first speakers use practices to correct their own talk themselves and second speakers refrain from correcting it directly. Instead, second speakers tend to initiate the repair of prior talk (Schegloff, Jefferson and Sacks, 1977). In other-initiated repair, a speaker claims some kind of problem in the prior speaker's turn. Repair initiations may problematise the entire turn through questions such as "pardon?", "what did you say?", "what do you mean by that?" or a repeat of the turn with a questioning intonation. Alternatively, repair initiations may problematise a specific part of the turn to be repaired. For example, questions such as "who?", "what?" and "who is X?" all display precisely where understanding or hearing has not occurred. These various repair initiations make relevant a repairing answer from the first speaker. Alternatively, a second speaker may supply a candidate understanding of the prior turn, such as "you mean X?" for the first speaker to confirm or reject.

Practices of repair temporarily disrupt the progress of talk. The requirement for a conditionally relevant next turn is suspended so that talk now deals with the identified trouble. These practices highlight how meaning and understanding are accomplished through interaction.

3.4.4: The organisation of turn design

The final organisation refers to variety of separate interactional practices, all relating to how a turn at talk is designed. The concept of 'recipient design' refers to how a turn is designed so that it fits the recipient who will hear and respond to it. For example, when introducing ourselves on the telephone we select the form of the introduction – forename, surname, work position and so on - based on how and how well the recipient of the call knows us (Schegloff, 1979). When talking about third parties, we may refer to them by name or an identifier such as "my boss" or "my sister" depending on the assumed level of knowledge of the recipient (Sacks and Schegloff, 1979). Similar assumptions of recipient knowledge are embedded in selections between technical 'jargon' and simplified 'lay' descriptions in talk (Mandlebaum and Kitzinger, 2007). These various practices show how turns are designed to be understandable to their recipients.

Turns can also be designed to display the state of knowledge of the speaker. When we make a declaration, such as "X is going to happen tomorrow" we claim knowledge of something, plus a right to express that knowledge (Heritage, 2008). We may design our turns to downgrade that knowledge claim in a number of ways (Pomerantz, 1988) e.g., "X might be going to happen tomorrow", "I think that X is going to happen tomorrow" and so on. Similarly, making an assessment of something also implies that we have knowledge of what is being assessed (Pomerantz, 1984a). If our knowledge of the assessable is not based on direct access to it, we may display this in the turn design of the assessment, for example with 'that sounds great' rather than 'that is great'. In assessment sequences, a first assessment

makes conditionally relevant a second assessment from the next speaker. In these instances downgraded responses such as 'that sounds great', 'that must be great' etc, can be heard to display the speaker's state of knowledge relative to others in the interaction as well as relative to the assessable (Heritage and Raymond, 2005). This indicates that turn design can make visible epistemic issues in talk.

A final feature of turn design is known as 'preference organisation'. This connects to sequences and adjacency pairs. As observed above, a first pair part makes a second pair part relevant in response. Frequently there are two alternative possible responses: invitations and offers make relevant an acceptance or refusal, assessments make relevant agreeing or disagreeing second assessments and apologies make relevant an acceptance or rejection. These alternative responses are not equivalent. In terms of maintaining social solidarity (Heritage, 1994) agreeing and accepting turns can be seen as 'positive' actions whilst disagreeing and refusing ones can be seen as 'negative'. Various empirical studies have noted that these positive and negative responses are performed differently. Positive responses tend to be immediate and explicit and negative responses tend to be delayed, softened and mitigated. This difference is seen in examples from Pomerantz's paper on assessments (1984a).

Extract 3: (Pomerantz, 1984a: p. 59)

```
A1:  T's- tsuh beautiful day out isn't it?
A2:  Yeah it's jus' gorgeous
```

Extract 4: (Pomerantz, 1984a: p. 60)

```
A1:  Well, it was fun Cla[ire,

A2:                      [Yeah I enjoyed every minute of

     it
```

In both extracts the A1 turn is an assessment and A2 turn an agreeing second assessment. The agreements are performed immediately. In extract 3 it occurs after a normal 'beat' between turns and in extract 4 it occurs in overlap. Additionally, both agreements are explicit and positioned at the start of the turn through the word 'yeah'. By agreeing the second speaker performs a 'preferred' action. This infers structural rather than psychological preferences and connects to turn shape. Positive responses are preferred and this is shown in the interactionally efficient ways they are produced. Negative responses are 'dispreferred' and are delivered differently to preferred ones.

Extract 5: (Pomerantz, 1984a: p. 70)

```
A:  God izn dreary.

    (0.6)

A:  [Y'know I don't think-

B:  [.hh it's warm though,
```

Extract 6: (Schegloff, 2007: p. 69)

```
1.  A: Yuh comin down early?

2.  B: Well, I got a lot of things to do before getting

3.     cleared up tomorrow. I don't. I w- probably
```

```
4.      won't be too early.
```

Extract 7: (Schegloff, 2007: p. 69)

```
1.   Emm:    [Wanna c'm] do:wn 'av [a bah:ta] lunch w]ith =

2.   Nan:                     [°it's js ] (    ) °]

3.   Emm:    = me? Ah gut s'm beer'n stu:ff,

4.           (0.3)

5.   Nan:    ↑Wul yer ril sweet hon: uh:m

6.           (.)

7.   Emm:    [Or d'y]ou'av] sup'n [else °(              )

8.   Nan:    [L et- ] I  :] hu.   [n:No: I haf to: uh call

9.           Roul's mother, I told'er I:'d call'er this

10.          morning
```

These extracts show various features associated with dispreferred responses. One feature is delay. In extracts 5 and 7 the speaker delays the timing of the response beyond the normal transition between turns. In extract 5 the disagreement marker 'though' is placed at the end of the turn, as is the report of not being early in extract 6. The initial parts of dispreferring turns are often taken up with actions that soften its oncoming negative content. In extract 6 the second speaker explains and, therefore accounts for, not being able to arrive early, whilst in extract 7 the second speaker gives an appreciation for the offer of lunch before accounting for not being able to attend. Finally, whilst preferred responses are often designed as explicit, dispreferred ones tend to be less so. Extract 5 is a relatively weak form of disagreement (Pomerantz, 1984a) whilst a refusal is implied rather than stated in extract 7.

Preference organisation demonstrates how interactions are organised to encourage positive responses and discourage negative ones. This is associated with the normative dimension of talk. A speaker producing the 'wrong' response to a prior turn may be accountable, or required to explain, this response. This is shown by the extra work that goes into the production of that turn. First speakers monitor for signs of an oncoming dispreferred response and may alter their original offer/invitation etc following a silence or apparent softening of a refusal (e.g., extract 7 lines 5 and 7). The study of preference organisation therefore tells us much about how social cohesion is pursued in interaction.

These four organisations are not an exhaustive list of all the phenomena a CA study might consider. In particular the increasing use of video data provides opportunities to analyse the relevance of non-vocal activities to interaction. However, beginning with these organisations enables a data extract to be analysed systematically to produce a detailed description of the interactions that occur. In particular the four elements combine to produce a 'sequential' description of interaction. The sequential approach considers how talk unfolds over time rather than looking at individual verbal utterances in isolation. In this way interaction can be understood as a dynamic process (Heritage 1997). As the discussion of sequence organisation above described, individuals typically orient to some proceeding talk when producing a turn. At the same time they may project (through preference organisation) a next action or range of possible next actions to be performed by the next speaker. Furthermore, by producing their next actions individuals display how they have understood prior talk. For example, the production of an agreeing second assessment displays

that a speaker is treating a prior turn as a first assessment. Apparent misunderstandings between individuals concerning what actions are being performed may become the objects of repair (Heritage, 1997).

This sequential approach enables conversation analysts to make empirically grounded claims about the unfolding of talk. Atkinson and Heritage write that the fact that "speakers understand an utterance by reference to its turn-within-sequence character provides a central resource for both the participants and the overhearing analyst to make sense of the talk" (1984: p.7). When responding to an utterance, a second speaker displays his/her understanding of it. This displayed understanding is open to observation to the first speaker as well as to the conversation analyst. Repair sequences may indicate attempts by one speaker to resolve perceived misunderstandings by another but any turn is relevant to the ongoing talk regardless of whether or not the second speaker 'correctly' understood the 'intentions' of the first. This is because it performs an action that shapes the unfolding interaction. In this way it is not necessary for analysts to attempt to interpret the psychological feelings or motivations of speakers in order to understand what is going on in the talk. Instead by analysing turns in sequence, CA can produce empirical descriptions of talk as social action.

Once a single data extract has been analysed, further analysis might proceed in different ways. The extract might form the basis of an extended case study, to be discussed in detail and perhaps contrasted with other examples in the same corpus or in existing published work. Alternatively, the extract, or a particular sequence of interest within it, could form the starting point of a collection of similar examples. The

analyst builds a model of the interactional phenomena that recur in the collection and seeks to explain their logic. Attention is paid to variations that may occur within the collection and in particular to deviant cases that do not appear typical. In either form, the aim of analysis is to describe the interactions that have been observed and assess what they demonstrate about the mechanics of interaction.

3.5: Conversation Analysis and institutional talk

It has already been noted that conversation analysis assumes the primacy of ordinary talk. The turn-taking system observed in mundane talk is the foundation for talk in all settings, including formal, institutional ones. In his analysis of telephone conversations in a suicide call centre, Sacks looked to uncover universal features of talk and did not assume that talk in that setting would follow some special logic. Similarly when analysing talk in medical, legal, educational etc environments, it should not be assumed that the institution will shape the interaction. CA takes the position that "context is both a project and product of the participants' actions" (Heritage, 2005: p. 109). Just because talk occurs in a physically institutional setting does not mean that the talk will be institutional. For example, we may make small talk in a doctor's surgery and talk about formal and informal issues at work. Context is not fixed; instead it is built and managed through interaction. The task of analysis is to show how "participants build the context of their talk in and through their talk" (Heritage, 2005: p. 109). For example, the context of a courtroom interaction is in part built up by chains of question and answer sequences between lawyers and witnesses, just as many church and legal ceremonies are recognisable

as such through their formulaic, often scripted interactions (Atkinson, 1982).

Drew and Heritage (1992) identify three basic elements of institutional talk. The first is that participants have institution-relevant identities and the interaction involves goals that are connected to those identities. Teachers teach and students study, patients present medical problems and physicians diagnose them. The second states that there are particular constraints on what is interactionally allowable in pursuit of those goals. In some legal, religious and business settings, turn–taking is predetermined or mediated and talk out-of-turn is liable to be sanctioned. Likewise, there are constraints against interviewees asking interviewers lots of questions. Additionally, whilst 'second stories' in ordinary talk are very common (Sacks, 1992) a therapist telling a client that he/she has personal problems too would be heard as deviating from the business at hand. The third element is that interaction involves special inferences and reason-making particular to the context. For example, any departure from the established wedding ceremony interaction may warrant inferences about the attitudes of those participating and the legitimacy of the ceremony itself (Heritage, 2005). Similarly, inferences may be drawn about the status of medical practitioners and teachers depending on their ability to produce answers to questions and display relevant knowledge.

In analysing institutional encounters, the task of CA is to identify what is institutional about the talk, what interactional practices are being employed for particular purposes and how their use matters for issues that are beyond the talk (Heritage, 2005). The analysis of institutional encounters has become well established in CA and studies have been

made of various institutional settings (e.g., see Atkinson and Drew, 1979; Greatbach, 1988; Drew and Heritage, 1992). This includes the study of medical encounters (often in primary care). Studies have looked at a range of topics including: areas of medical specialism; the overall structure of typical medical encounters; common medical sequences such as history-taking and advice-giving; plus issues of medical concern, such as patient resistance (see overviews in Heritage and Maynard, 2006a and Heritage and Maynard, 2006b; also ten Have, 1989; Peräkylä, 1995; Pilnick and Coleman, 2003; Stivers, 2005). Here I discuss two particular studies that highlight the contribution conversation analysis brings to the study of medical interactions and that offer insights relevant to this doctoral study.

In an investigation of 70 General Practice consultations in the Netherlands, ten Have (1989) produced an empirically based description of how sequences in a typical medical encounter unfold. He describes an 'ideal sequence' which begins with an opening, followed by a complaint, an examination or test, diagnosis, treatment/advice-giving and finally, closing. These sequences are a product of the interaction between practitioner and patient. Practitioners generally initiate the start of each sequence and may also orient to a current or oncoming phase by referring to what is happening now or about to happen. Patients sometimes use 'free' moments to introduce some talk out of sequence, for example introducing a new medical complaint when the doctor is writing a prescription. In this study ten Have argues that the practitioners orient to consultations as a form of 'service encounter' in which patients are seen to request a service which the practitioner should then provide. As an ideal type this sequence can be observed across multiple medical settings.

The above study focuses on the overall sequential organisation of medical encounters. Others have looked at particular sequences of talk. This includes analysis of patient explanations for symptoms and illness (Gill, 1998), the format of practitioner questions (Robinson, 2006) and the format of diagnostic delivery (Maynard, 1991). Practitioner questions to patients are frequently 'optimised' to assume a best case or 'no problem' type answer (see discussion in Heritage, 2005). For example, questions such as "is your father still alive?" and "did the birth go well?" are designed so that a 'good news' answer requires only a simple affirmation and no further talk. However, questions about lifestyle behaviours - drinking, smoking, food intake etc - are not optimised (Heritage, 2005). Instead, they are designed to encourage disclosure by assuming a problem response. For example, there are non-equivalent normative issues at stake in answering "how often do you drink?", compared to "do you drink?" or even "you don't drink do you?"

Sorjonen, Raevaara, Haakana at al (2006) analysed where in the consultation these kinds of lifestyle questions arose and what consequences this had for the ongoing interaction. Using Finnish data they looked at consultations where a medical problem was presented for the first time and where the practitioner topicalised lifestyle as a new issue in the patient's treatment. They found that when the practitioner asks a lifestyle question immediately or soon after the patient has presented a new problem, the question is hearable as suggesting a close linkage between the problem and lifestyle. This type of sequence was often found to occur when a problem was presented as subsidiary to the main health condition being presented. Alternatively, lifestyle questions may be produced during history-taking

or examination, in response to the problem the patient has reported as the reason for the visit. In these instances the questions are less hearable as connected to the patient's prior talk about the problem. Additionally they may be delivered after other diagnosis-seeking questions and so may be heard as less important than those other questions.

Questions about smoking, drinking etc raise the possibility that there is something 'wrong' with the patient's lifestyle. Patients frequently produce 'no problem' responses to these questions. These range from simple rejections to answers that claim to a 'normal' level of behaviour. The doctor may then ask a question about specific frequencies of drinking, smoking etc but, whilst treating the patient's answer as not sufficient, they do not actually challenge the lifestyle behaviour. The topic is often not pursued after this point and the practitioner may not produce any kind of evaluation of it or advice connected to it. By contrast, patient answers which explicitly or implicitly orient to a lifestyle problem are followed by discussions of the problem and advice-giving. Sorjonen at al conclude that whether or not lifestyle becomes a relevant topic in the consultation is contingent on how patients respond to questions about it. Consequently, advice-giving about lifestyle is locally and collaboratively organised.

CA studies of institutional talk directly or indirectly offer comparisons with mundane talk. Such comparison indicates that although talk in institutional settings may be based on the same turn-taking norms and procedures as in ordinary ones, they tend to be used more restrictively (ten Have, 1990). There are typically reductions in the types of interactional practices occurring, the phases in which they are produced

and restrictions in the interactants who produce them (Heritage, 1997). These restricted usages are one way in which the particular institutional identities, functions and relationships in the setting can be observed. This study is therefore interested to compare talk in specialist obesity clinics to ordinary talk. As becomes clear in the analysis chapters, there is also much scope to compare my data on talk in secondary care settings to previous medical CA studies, which have tended to focus on general practice.

3.6: Limitations and possibilities for conversation analysis as a form of sociological enquiry

CA has staked a claim for itself as a distinctive form of sociological enquiry. Its emphasis on naturalistic data collection, the interaction order and practical reasoning sets it apart from many other approaches. Unsurprisingly therefore it has been criticised by those who do not share its philosophical underpinnings. It has been criticised for 'just' focusing on talk as opposed to other issues that go on in a setting, for using samples that are too small to tell us anything about the world and for ignoring broader 'power' issues of gender, class etc (e.g., Coulthard 1977; Moerman, 1988; Hammersley and Atkinson, 1995). From a CA perspective it is possible to respond that these criticisms miss the point. Conversation is a major medium of social interaction, one through which class, gender and so on are made visible, and therefore forms a valid object of study. Furthermore, since practices in the interaction order are universal, we can learn as much from one data source as we can from one hundred (Sacks, 1992). Criticisms have also been made of the data collection process. These criticisms state that when interactants are aware of being recorded

their behaviours are likely to be affected by this knowledge; they may be uncomfortable, they may speak unusually formally and they may withhold talk (Hammersley, 2003). This implies that recorded interactions are somehow less 'real' than they would have been if the tape recorder or camera had not been there. In response however, it can be argued that whilst interactants may react to being recorded, these reactions will not necessarily be negative ones. In any case positive and negative reactions are both a kind of social action, and social action is the object of analysis (Speer and Hutchby, 2003). Therefore, recorded interactions are no less analytically 'real' than unrecorded ones.

Alongside criticisms from outside CA, there are some notable debates occurring within it. One such debate concerns the use of quantification in analysis (Schegloff, 1993; ten Have, 1999; Heritage, 2005). Quantification requires the kinds of generalisations and categorisations that Garfinkel turned away from in favour of detailed empirical description. Furthermore, the frequency of an interactional phenomenon cannot be assumed to signal its universality (Schegloff, 1993). Despite this, CA studies do often make quantitative references (ten Have, 1990). For example, analysts might claim that a particular interactional phenomenon occurs 'frequently' or 'rarely' in the dataset, or use tables showing frequency counts. Typically these quantitative claims are designed to provide a guide to the data rather than any wider claims to universality etc. The detailed discussion of transcripts remains the primary focus.

Another debate concerns how far CA findings can be applied to or combined with non-CA studies. Garfinkel (2002) describes conventional

sociology as 'Formal Analysis' and criticises it for relying on common sense categories rather than studying them. If 'female', 'home' or 'middle class' are typifications in daily life, so they also are in sociology. Analysis should aim to show how they are manifested through practical reasoning rather than to assess what they 'are' or what 'effects' they have. Furthermore, whilst CA emphasises naturalistic data collection and the empirical analysis of talk, many sociological studies collect interview data and analyse them following the Weberian principle of *verstehen* (Weber, 1949). This approach states that it is possible to interpret and understand actors' perspectives based on their interview talk. However, by contrast, the CA approach is sceptical "about a model of social action in which aspects of cognition are used to explain social action," (Pomerantz, 2005: p. 93).

With regard to these incompatibilities, what relationship can CA have wider, 'mainstream' analysis? Can CA findings comment on, 'prove' or 'disprove' other sociological studies (and vice versa)? It is possible, following Sacks (Silverman, 1988), to take a deliberately 'agnostic' stance towards any studies which do not share an ethnomethodological foundation. Alternatively, it is also possible to connect CA findings to wider sociological issues and debates. For example, ten Have's (1989) 'ideal sequence' of the consultation, discussed above, has resonance with descriptions of medical encounters produced in earlier observational studies (e.g., Byrne and Long, 1976). In addition, various CA analyses challenge many late 20th century observation-based discussions of medical interactions by replacing the concept of 'medical dominance' with descriptions of interactional asymmetry (see chapters 2 and 7 in this thesis and overview in Heritage and Maynard, 2006a). In a recent paper, Toerien and Kitzinger (2007) demonstrate how

practical accomplishments observed by CA can be seen to exemplify abstract sociological concepts. They analysed video recordings of interactions in beauty salons and observed how beauty therapists combined their physical work with talk that engaged with the client as an individual. Toerien and Kitzinger connect their findings to the sociological concept of 'emotional labour' (Hochschild, 1983) which highlights the management of emotion of the self and other by those in paid (often service-based) work. They argue that the therapists' activities in interacting with clients as individuals can be seen as emotional labour in action. This use of CA in this study makes a particularly useful contribution to sociology as it enables direct observation of how emotional labour is achieved in practice, in contrast to other studies which use interview or text-based data to represent its existence, 'meaning' and consequences.

In Toerien and Kitzinger's study the connection between CA and other sociological interests emerged from the data. However, in other cases, they can be the starting point for study and lead to the incorporation of survey methods and statistical analysis into the research design. A key example of this is the study by Heritage, Robinson, Elliot at al (2007) on unmet patient concerns. This interventional study is based on the medical and sociological assumption that patients routinely attend primary care consultations with more than one health concern to report to the practitioner but do not present them all during the encounter. Heritage, et al use CA to consider how the sequential organisation of talk might play a role in this under-reporting, noting for example that practitioner opening questions (see chapter 5) often assume that the patient has a single problem to present. During the study itself, participating patients were asked to complete a survey before their

consultation noting how many health concerns they intended to present to the practitioner. This was then compared to the number of concerns they presented in the actual consultation. During the consultation, following discussion of the first problem presented, practitioners solicited further concerns in different ways. One group asked: "Is there something else you want to address in the visit today?" Another asked: "Is there anything else you want to address in the visit today?" Subsequent CA and quantitative analysis indicated that patients in the "something" group were far more likely to introduce further concerns than those in the "anything" group and in the study's control group.

The authors connect this finding to the CA observation that "something" prefers a "yes" answer whilst "anything" prefers a "no" one. The findings provide very specific insights for clinical practice as well as for sociological interest in the doctor-patient relationship. The study can therefore be seen as an example of how CA can combine with other sociological methods and concerns. However, it can also be seen to breach 'normal' CA practice by moving away from unmotivated looking and employing non-ethnomethodological methods and quantifications. Debates over how far CA should embrace these kinds of external methods and concepts are sure to continue (Schegloff, 1993 and 1997 and ten Have, 1999). In the next chapter I demonstrate where I place my own analysis within these debates, in particular where they concern the use of quantification and CA's relationship with sociology.

3.7: Conclusion

In this chapter I have discussed the theory and practice of conversation analysis in order to establish it as the appropriate interactional approach to employ in my study. I have shown how its methodological foundations enable innovative and convincing analyses of talk in various settings – including medical ones, such as consultations about obesity. In the next chapter, I outline how the abstract requirements of CA were translated into practice during the development and implementation of my project.

Chapter 4: Methods

4.1: Introduction

This chapter describes the methods applied in the PhD fieldwork. So far in this thesis I have reviewed the literature on obesity as a social and sociological phenomenon and argued that an interactional approach is needed to investigate talk in obesity related medical consultations. In the previous chapter I set up conversation analysis as the appropriate interactional approach for this project and in this chapter I describe how I did this in practice. I outline the development and finalisation of my research design, ethical considerations, data collection and the process of analysis. As will become clear, activities, changes and constraints in the fieldwork sites played a major role in defining the research plan and have also proved relevant to analysis. They are therefore described in detail. I demonstrate that, although some research decisions were made on strategic grounds, they nevertheless resulted in analytic benefits, enabling the collection of rich data ideal for conversation analytic work.

4.2: Research Design

4.2.1: Early development of the research plan

The origins of this PhD project lie in a Master's course I completed in 2004-5. This was a Master's in social research methods and was designed to lead into a doctorate. At the outset of my studies, my supervisors and I agreed that I would study medical interaction in some

form and that my MA research would develop into a conversation analytic project during my PhD. I was interested in studying medical interactions in the context of obesity care, as its status as 'more than' a medical condition suggests analysis can contribute to sociological thought on patienthood, face, individual versus collective behaviour, attitudes, responsibility, gender and so on. On further reading it became clear that whilst much sociological attention has been paid to what the label obese 'means' in modern society, relatively little has been paid to what actually happens to people once they have been given that medical label and in particular how they talk about it with medical practitioners. This indicated that a study of medical interactions regarding obesity could make a valid contribution.

The next step was to establish whether any possible fieldwork sites were available. A local hospital (called 'Arlingford' in this project) had a regular Weight Management Clinic treating obese outpatients and fortunately the consultant running the clinic was very enthusiastic about research taking place. He allowed me to sit in and observe his clinic consultations and agreed in principle to further research involving recordings taking place. I visited the Weight Management Clinic (WMC) throughout my MA year, writing up observations from memory and using them as data for my research project. The clinic was held each Wednesday afternoon and was run by the consultant, a diabetes specialist with an interest in obesity. The clinic itself had no formal standing in the hospital and was run on a voluntary basis. In the NHS, most funding for obesity treatment is given to primary care General Practices so the secondary care hospital had no obligation to provide this service – a factor that proved highly relevant throughout my research. During my MA year the consultations were conducted by the

consultant, a local GP, and an honorary consultant who also an obesity researcher at a local university. Patients were referred to the clinic by their general practitioners or other hospital departments. All were obese and committed – in theory at least – to making an effort to lose weight. Many had co-morbidities associated with excess body weight, in particular type-2 diabetes, but also heart disease, polycystic ovary syndrome and joint problems.

Attending the clinic and observing consultations enabled me to determine that the clinic was an appropriate site in which to conduct fieldwork. As all the patients attending the clinic were obese they represented the key group I was interested in studying. Furthermore, the clinic was set up specifically to treat obesity and its associated problems, so the entirety of each consultation provided relevant data. Finally, specialist, secondary care encounters have been relatively under-explored in the study of medical interactions (including CA), so researching in the WMC would provide an opportunity to redress the balance and develop some novel findings. My time at the WMC also demonstrated the limitations of observational methods in studying interaction. I gained a great deal of useful data from my observations but grew frustrated that my memory recall could provide little more than glosses of the interactions I found interesting. I realised that in order to provide a satisfactory analysis of these occurrences it was necessary to record them in some way and analyse them in detail. This in turn highlighted the benefits of a conversation analytic approach.

Towards the start of my PhD the proposed research came under threat when the consultant in charge of the WMC left the hospital to take up a professorship in Australia. By this time, the GP had also stopped

attending, leaving the honorary consultant the only practitioner in the clinic. The hospital management took this development as an opportunity to suggest that the WMC close down – therefore saving on its administration costs. It was decided that the clinic could stay open in the short term for the existing patients but only if it did not use any hospital resources and if the clerical staff, who collected patient notes and typed up appointment letters etc, were happy to fit it into their workload. The new diabetes consultant, 'Dr Lin' arrived at the hospital in January 2006 and was keen to take over the running of the clinic. By this time, the honorary consultant had also announced that he was emigrating to the southern hemisphere. The hospital management remained reluctant but ultimately it was decided that the clinic could remain open in a reduced format – changing from weekly to fortnightly and then monthly. Dr Lin would run it on his (Wednesday) afternoon off but would not receive any clerical support. The hospital reserved the right to close the clinic entirely at any point if it was seen to be negatively affecting its official business. In response, Dr Lin reduced the number of patients in the clinic, discharging rare attenders and those who were near to being 'cured' and transferring others to alternative hospital clinics. In particular, a large number of obese patients with diabetes were transferred to one of Dr Lin's official, funded, diabetes clinics. This became a specialist Diabetes and Obesity Clinic (DOC) treating patients for both conditions in the same consultation.

Throughout these developments I continued my observation at the WMC. I was very fortunate that the clinicians there kept me up to date with the various changes and were very encouraging about my PhD project. I intended to conduct my fieldwork throughout the second year

of my PhD (2006-7) and needed to gain formal ethical clearance before I could begin. In order to conduct research in the NHS it is necessary to gain approval from a local Research Ethics Committee (REC) as well as Research and Development (R&D) clearance to work in a hospital. This whole process takes 6-9 months, but before I could begin I needed to make a final decision on where to conduct the fieldwork. I was by now very familiar with the WMC and had many ideas about how I could conduct my study there, but I needed to have a plan in case it did not stay open long enough for me to collect sufficient data. Consequently, with Dr Lin's permission I started to observe consultations in the Diabetes and Obesity Clinic (DOC) with the aim of assessing whether that would also be a suitable research site. I quickly realised that DOC consultations also contained a great deal of interesting talk about obesity. Although much of the talk went into great detail about diabetic control and medications, the overall focus of the encounter tended to be on weight loss as the key to easing the ill health associated with both obesity and diabetes. Therefore there were a lot of discussions about weight, weight loss, diet and exercise. Since the consultations were conducted by the same doctor as in the WMC, and with some of the patients I had seen there previously, I also gained a sense of how particular institutional settings may shape and be shaped by the talk that goes on, even when the interactants remain the same (for example see chapter 8 on the different accomplishment of closings in the WMC and DOC).

I altered my research plan to include recordings in the DOC and WMC. I aimed to fill my sample with patients from both clinics – roughly half from each – and record their consultations with Dr Lin. If the WMC were to close, I would be able to increase my sample in the DOC and

be sure of getting enough data. If it stayed open I would benefit from recordings in both settings, enabling some form of comparison if appropriate.

4.2.2: Finalisation of the research plan

The finalisation of the research plan involved deciding who to record, how to record them and for how long. Once again, certain practical constraints played a role in shaping the plan. However, where I could exercise a choice, I planned the research in a form appropriate to the principles of conversation analysis. This emphasised the recording of naturally occurring interactions in a manner allowing repeated viewings of the data. Additionally, a deductive approach was preferred to the pursuit of a pre-set hypothesis or analytic concepts that might skew data collection.

Sampling decisions were also guided by CA's tendency to privilege the detail of data over quantity (Silverman, 1993); meaning a small sample was appropriate. Since obesity is a long-term chronic condition, typically treated over months or years rather than in single visits, it seemed analytically useful to capture a sense of how treatment changes and progresses over time. I therefore decided to record patients over a number of visits. I elected to aim for a sample of 20 patients and to record each of their consultations over a period of 12 months. As patients typically had up to four appointments a year this would capture a more than sufficient amount of data (allowing for sample attrition, between 40 and 80 recordings) without placing an unduly heavy burden on participants. In keeping with many other CA studies, I did not set out to generate a representative or probabilistic

sample and instead aimed to produce detailed descriptions of typical interactions in the setting (ten Have, 1999). On these grounds all patients attending the clinic would be regarded as eligible for inclusion and the sample would be filled by the first 20 who consented to take part. The only exclusions were made on ethical grounds (see below). Once my sample was full I would attend and record the return visits of all patients in the sample for the 12 months following the date of each patient signing up to join the study.

Another consideration was how to record the interactions. As with many CA studies, I planned to stay outside the room whilst the consultations were recorded – in order to maximise the 'naturalness' of the interaction (ten Have, 1990). This meant that I needed a reliable means of recording the consultations as I would have no direct observations of my own. At the start of my PhD I assumed that I would use an audio recorder to capture the consultations. There was relatively little movement in the consultations – beyond stepping on the scales to be weighed – and a small audio recorder would be far less intrusive than camera equipment. However, as my observations in the clinic continued, I reassessed this assumption. I noticed that whilst there was little movement around the consultation room, there were often long periods of silence. Sometimes these were the result of the doctor looking in his notes, or the patient undressing and so on, but at other times the silence hinted at some kind of 'trouble' going on in the talk (Sacks, Schegloff and Jefferson, 1974). Having only audio recordings would mean that when I reviewed the data I would not be able to assess whether a pause may be associated with an ongoing non-verbal action or whether it could tell me something about tension in the interaction. By contrast, a video record would better enable me to

make these analytic assessments. Furthermore, as I continued my CA reading, it became clear that in face-to-face talk non-vocal actions, such as gaze and head movement, may be crucial to understanding simultaneous verbal actions. Therefore video recording became a necessity to ensure the capture of both the spoken and non-vocal actions that are central to interaction (Heath and Hindmarsh, 2002).

4.3: Ethical considerations

As my fieldwork involved recording confidential medical interactions, ethical considerations played a major part in the research design. These mostly concerned ensuring the informed consent of participants and maintaining their anonymity. Specific NHS REC requirements determined the specific form with which some of these concerns were met. More generally, the principles of the British Sociological Association (2002) were applied to ensure ethical conduct.

NHS REC guidelines state that in order to ensure informed consent, potential research participants must have at least 24 hours 'thinking time' between being told about a project and stating whether they would like to become involved with it. In addition, a clinician not a researcher should make the first approach. Therefore it would be necessary to post a project information sheet to all eligible patients before they came to the clinics. This information sheet would include a cover letter signed by Dr Lin asking the patient to consider taking part and a tear-off slip for patients to post back to me if they were happy for me to approach them at the clinic. If patients returned the slip to me I would be free to approach them directly on their arrival at the clinic. If they did not, I would need to hand them another letter signed

by the doctor asking them to agree to talk to me. Following either form of agreement, I would explain to the patient the detail of my project and ask him/her to consider taking part. I would also explain the procedures through which I would ensure anonymity and the security of my data. Patients who agreed to take part would then sign a form outlining their consent to take part and right to withdraw at any time. On their return visits I would renew patients' consent verbally. Dr Lin also signed a consent form agreeing to similar anonymity procedures.

As mentioned above, I excluded, on ethical grounds, any patients who were unlikely to be able to give informed consent to take part in the study. Therefore patients under the age of 16, patients with learning disabilities and patients with limited English language skills were automatically excluded.

4.4: Data collection

I received REC and R&D clearance for my project in the summer of 2006 and started my fieldwork in October 2006. As with my research design, I set out to conduct data collection in a manner consistent with CA principles. Therefore my main aim was to collect clear audio and video records of naturally occurring clinical interactions.

The first phase of fieldwork involved signing up patients to complete the sample. In order to post information sheets to patients before they came to the clinics the hospital allowed me restricted access to their electronic records. I was able to look up how many patients were booked in to a particular clinic plus the appointment times and home addresses of each patient. I was also able to see some of their notes

and was able to check whether each patient booked in to attend the clinic was receiving treatment for obesity and whether they fitted within my ethical criteria. Based on my own timetable and the number of eligible patients booked in with appointments, I elected to attend certain clinics, usually one every two weeks. I then posted out information sheets to all eligible patients around a week in advance of their appointment.

On each fieldwork visit I arrived at the hospital before the clinic started, set up the recording equipment then sat in the patients' waiting area. When patients I had identified as possible participants arrived, I approached them to talk about the project. If they had returned the tear off slip accompanying the information sheet I was able to approach them directly, otherwise I handed them the second letter before introducing myself. I gave the patients a brief description of what I was interested in studying and how I would conduct the data collection before asking if they were interested in taking part. If patients consented then they signed multiple copies of the consent form, keeping one for themselves. At the start of data collection I was concerned that patients would prove reluctant to be video recorded since to many obesity is a sensitive and very visual condition. With this in mind, I planned to suggest to patients that they could be audio recorded only if they appeared very reluctant to be videoed. In practice however, I had relatively little trouble signing up participants. Many patients had been involved in some form of medical research before, including being video recorded, and others commented that they wanted to 'give something back' to the NHS by taking part in my project. No patients requested audio recordings only. After 6 clinic visits I had signed up 18 patients for the study – 10 from the WMC and

8 from the DOC. By this stage some of the patients were due to have their next appointments so in order to keep the different stages of the fieldwork separate, I decided to close the sample at 18. My early analysis had also shown that I was collecting rich data so I was satisfied that I would have enough recordings even with this reduced number. After closing the sample I continued to access the hospital records to check the appointment dates of the patients I had signed up and returned to the clinics to record their subsequent consultations.

The process of recording was guided by two aims. The first was to ensure the collection of recordings with good audio and visual quality to enhance the reliability of the data (Perakyla, 1997). The second was to ensure that the recording process was unobtrusive so that that, as far as possible, participants would not be affected by the sight of the equipment, experience discomfort at being recorded and so on. In order to satisfy both aims, I attached a powerful external microphone to the camera and placed it in a corner away from all interactants and in a position where patients would have their backs to it for most of the encounter. A wide angle lens was also used to maximise camera coverage and ensure that activities such as patients entering the room and walking to the scales to be weighed would also be recorded.

For each recording I entered the room before the consultation began to turn on the camera and turned it off once the meeting was over and the patient had left. The doctor was also able to operate the camera via a remote control device and used it to suspend recordings during any physical examinations that required the patient to undress.

After consultations patients frequently commented to me that had they forgotten all about being recorded and could not see the camera. However, references to the camera were common and occurred in specific ways. Patients frequently made jokes about being filmed during opening or closing greetings, where 'small talk' tends to take place. They also occurred in complaint sequences. Patients would at times strengthen their complaint about a third party – typically the patient's own GP or NHS bureaucracy – by stating that they 'didn't mind saying it on camera' sometimes turning to look at the camera directly. In contrast, the doctor sometimes referred to the presence of the camera as a justification for not getting involved in a complaint, stating for example he 'couldn't possibly comment' whilst his words were being recorded.

By March 2007 I had made a number of successful visits to both clinics and had a total of 22 usable recordings. Dr Lin then informed me that he was taking up a new job at 'Cleedon' – a nearby hospital where much specialist diabetes care and obesity surgery takes place – meaning he would be leaving the hospital at the end of July. Consequently, the WMC would close completely and it might be some time before a successor to the DOC was appointed. I faced a decision over whether to stop recording when Dr Lin left the hospital or try to continue recording in some other form – for example by seeking the consent of his successors to record their consultations. At this point I would still be able to conduct recordings for a further 4 months and would be likely to achieve a total of 40 recorded consultations. I decided that this represented a more than sufficient number for detailed CA analysis and therefore decided to end the fieldwork early when Dr Lin left the hospital. As many decisions about the end of data

collection are taken for somewhat arbitrary reasons, it was actually quite satisfying to feel that this project was coming to a natural close. My fieldwork ultimately took place over a period of 9 months. In that time I collected a total of 39 usable recordings, about 13 hours of data. The spread of recordings is represented in the tables below. Table 4.1 provides information about recordings in the Diabetes and Obesity Clinic and table 4.2 the same information for the Weight Management clinic. Each table gives the pseudonym and study number for all the clinic patients who participated in the study with 'R' marking the dates on which their consultations were recorded. In table 4.2, the X's seen next to some R's represent occasions when the consultations were recorded but the microphone was not switched on, meaning the data were not usable.

'Name' and study number	Nov 06	Dec 06	Jan 07	Feb 07	March 07	April 07	May 07	June 07
'Rupert Bennet' 7206	14th R				13th R			5th R
'Desmond Bright' 5384	14th R		9th R					5th R
'Lucy Atkins' 1485		12th R			27th R			
'Atif Beke' 2974		12th R					8th R	
'Gwen Philips' 2021		12th R			27th R			
'Kevin Britton' 1869		12th R		13th R				5th R
'Pam Nesbit' 2843			9th R					12th R
'Adam Foster' 7801			9th R					5th R

Table 4.1: Table showing the spread of recordings in the Diabetes and Obesity Clinic

'Name' and. study number.	Oct 06	Nov 06	Dec 06	Jan 07	Feb 08	March 07	April 07	May 07	June 07
'Julie Gibson' 4901	11th R –X								13th R
'Linda Jones'	11th R –X							23rd R	
'Timothy Dobson' 7244	25th R					14th R			
'Becky Lord' 3768	25th R			10th R					13th R
'Brenda Timms' 7631	25th R			31st R				23rd R- X	
'Jim Barnes' 8986		8th R							
'David Powell' 1341		8th R			28th R				13th R
'Miriam Dean' 6417		8th R						23rd R	
'Damian Brook' 5945		8th R		31st R				23rd R	
'Ian Graham' 3430			13th R						13th R

Table 4.2: Table showing the spread of recordings in the Weight Management Clinic

The early end to data collection was another instance in which an unexpected constraint resulted in an analytic benefit. My recordings include a significant number of cases where the doctor and patient have to manage the fact that they are meeting for the last time and, in

the case of the WMC, the likelihood that that the patient's specialist obesity care is coming to an end. These factors sparked my interest in the closing sequences of the consultation (chapter 8) and proved relevant to my analysis.

4.5: Clinic activities

During all my visits to the WMC and DOC I had many opportunities to observe the general running of the two clinics plus talk to the patients and various practitioners working there. I kept notes of these observations and was careful to record the institutional practices, constraints and changes occurring in the clinics during my fieldwork. I found that these features proved very relevant to understanding the interactions even though they were not always referred to explicitly by the interactants. For example, appointment and prescription forms (see DOC, below) are often handed over without any accompanying explanation and assumptions are expressed about next appointments and how patients will receive their prescriptions. These features are treated as easily understandable by the interactants but are less clear to an external observer without additional knowledge of the setting. Therefore in this section I provide a detailed description of the activities that typically took place in each clinic during the period in which I was collecting my data. I do not suggest that any of these features necessarily determine the interactions that go on and do not treat these ethnographic data as equal to the video data. Instead, they inform the CA analysis (Maynard, 1984) by providing necessary background information about the setting and its activities.

4.5.1: Diabetes and Obesity Clinic

The DOC takes place in a large general clinic unit in the hospital. It runs each Tuesday afternoon alongside a number of other clinics. Most patients in the DOC are both obese and have poor diabetic control. They are referred to the clinic by GPs and other hospital clinicians with the aim of treating both problems. My fieldwork sample included patients who had previously attended the WMC and one patient who had been newly referred to the DOC by another hospital consultant. Others had been attending for some time.

Patients are given an arrival time that is earlier than their actual appointment. On arrival they report to the general clinic reception, where a receptionist asks them to wait until their name is called out by a nurse. The nurses take them into a small room where they are weighed. This weight – which the patients can also see – is noted by the nurse and attached to the front of the patient's notes. The patients then sit and wait once more until called for by a phlebotomist. Once called, they go into another small room and have some blood taken to have their sugar levels tested. The patients are not told the results of this test; the results are passed on to one of the nurses who attaches them to the patient's notes. (This was the general pattern until near the end of the fieldwork, when the phlebotomy service was withdrawn due to funding issues). In some cases patients are also invited to have eye-screening for diabetic retinopathy. Patients then sit and wait until called by the doctor.

The doctor typically comes out of his consultation room a few moments after the previous patient has left, picks up the notes of the next

patient (which are placed in a pile on a table outside his door), takes the notes back into his room and reads them for a couple of minutes. He then walks over to his door, opens it to look into the waiting area and calls out the name of the patient.

The patient then enters the room – sometimes accompanied by a spouse or family member. The consultation usually begins with some small talk followed by an opening question from the doctor about the patient's progress between appointments (or in the case of the patient attending for the first time, a description of the referral letter and an invitation for the patient to comment on his condition). Patients typically answer with some relevant information about their weight, their diabetes, their drug prescription or some health problems associated with their condition and this becomes the first topic for discussion. The doctor may then ask some other general questions – for example if the patient has answered about weight he may ask a question about the patient's diabetic control and this may also be discussed. The doctor then asks the patient to list the medication he/she is taking and makes a note of them, including any dosage changes. He then looks at the patient's blood test and weighing results and compares them to previous results by looking in his notes. Depending on the patient's particular health status, the doctor also may conduct physical examinations including as pin-prick tests, blood pressure checks, measurement of waist circumference and body fat levels.

The doctor makes some kind of assessment of the patient's overall progress before discussion moves on to treatment options. In the case of obesity, patients undertake a range of treatments. All patients are

expected to control their diet and attempt to exercise, if physically able. Some patients are also prescribed anti-obesity drugs. During the period of fieldwork orlistat (also known as Xenical) and sibutramine (also known as Reductil) were commonly recommended and towards the end of data collection rimonabant (also known as Accomplia) received a clinical license and was sometimes recommended. Surgical treatment in the form gastric banding is also available to some patients if they have not achieved success with other interventions. Patients seeking to change their diet are frequently referred to a hospital dietician but the provision of other treatments is more circuitous and complicated. Payment for obesity and some diabetes medications comes from primary rather than secondary care. Therefore, although he is a diabetes and obesity specialist, the doctor cannot always prescribe medications for these conditions. Instead, he recommends a new drug to the patient's GP and requests that the GP prescribe it. In the DOC this is done through a standard form which the doctor fills out and gives to the patient to drop off at his/her GP surgery. Obesity surgery takes place at another hospital in the region, called 'Cleedon' in this study. Cleedon is in a separate funding area and again the patient's GP rather than the hospital is expected to fund surgery there. In cases where the doctor and patient agree that the patient should pursue surgery the doctor writes to the GP and ask him/her to complete a referral form and send it to Cleedon. A consequence of these arrangements is that at the end of the consultation the patient may not be certain of receiving his/her recommended treatment. In some cases GP's did prove resistant to prescribing certain treatments – especially expensive and relatively 'ineffective' anti-obesity drugs.

After discussing treatment, the doctor typically asks if the patient has any other concerns and then hands over a number of forms. These forms are the prescription form mentioned above, details of any further tests to be taken and a form with the patient's next appointment date to be handed in to the clinic reception. The doctor often checks the appointment date with the patient and mentions the letter he will send to the patient's GP summarising their discussion. This is typically followed by terminal greetings after which the patient leaves the room. Some of the extra tests the doctor recommends are required to be conducted immediately after the consultation, so upon leaving the room the patient may talk to one of the clinic nurses about getting them done.

Patients are automatically given a follow-up appointment, unless they have been discharged from the clinic. They typically have appointments every 3 to 4 months but may have them more often if they have very severe health problems. In any one clinic, there are typically two or more patients who do not attend their appointment and because of this the hospital overbooks the clinics, so that there are more booked-in patients than available slots. Appointments are scheduled to last for 15 minutes (30 minutes for new patients), but in practice their length varies between 10 and 45 minutes.

4.5.2: Weight Management Clinic

The Weight Management Clinic takes place on Wednesday afternoons in the Clinical Nutrition Unit of the hospital. Consultations are conducted in a nurse manager's office; a major reason for this location is that the office contains a set of industrial, highly-calibrated weighing scales,

suitable for weighing people with extremely high body weight. By the time of the fieldwork recordings, the clinic was run on an ad-hoc basis with no nurse or receptionist support. No new patients are being taken on so all appointments are follow-ups. Clinics take place between monthly and fortnightly and vary from being fully booked to having only one or two patients on a particular date. As in the DOC, appointments are scheduled to last for 15 minutes but vary in practice and patient non-attendance is a common occurrence. On arrival at the clinic patients sit in chairs outside the consultation room and wait until called by the doctor. Once the doctor has finished with a patient he usually spends a few minutes in the consultation room reading the next patient's notes, (kept in a pile in the room), then he walks over to the consultation room's door and calls out the name of the next patient.

After the patient enters the room and greetings are exchanged the doctor typically asks an opening question that invites the patient to give an update on his/her progress between consultations. The doctor may then ask further questions about the patient's weight loss activities and ask about any medications being taken. He then invites the patient to walk over to the scales to be weighed. Sometimes additional examinations such as blood pressure checks and body fat measurements are carried out. The doctor makes a comment on the weighing and examination results as well as the patient's general progress. Then talk moves on to treatment discussion. The available weight-loss treatments are the same as in the DOC; diet and exercise regimes, visits to a hospital dietician, drug therapies and surgery. Once again, financial constraints mean that the doctor can only recommend drugs or surgery to the patient's GP rather than prescribe them directly. In the WMC there is no standard medication request form;

instead the doctor puts the recommendation in his routine letter to the GP and the patient must then make a GP appointment to request a prescription. In the case of surgery, the doctor writes to the GP and asks him/her to send off a referral form.

After the treatment discussion the doctor asks if the patient has any other concerns and then picks up a Dictaphone and dictates his letter to the GP. On occasion he breaks off from his dictation to ask the patient a question or provide the patient with a clarification of what he is saying. Patients also sometimes interrupt the dictation with factual corrections of what the doctor has just said. Following letter dictation the doctor hands over any forms for further tests then suggests a next appointment date. Terminal greetings take place and the doctor escorts the patient out of the room.

This describes the typical running of the two clinics. Obviously individual consultations vary and the description here should be regarded as an 'ideal type'. Nevertheless, this ideal type shows that despite their institutional differences, encounters in each clinic unfold in a similar order: greetings, problem solicitation/update, examination, treatment discussion and recommendation, closing. With the update phase in place of problem solicitation, this order closely resembles the classic typology observed by Byrne and Long (1976) in primary care encounters and ten Have's (1989) CA description of the consultation as a 'genre' (see chapter 3).

4.6: Transcription and Analysis

After each fieldwork visit I watched and digitised the recorded consultations and made notes on them. I noted how the consultations were opened and closed, the order and length of different phases, topics of discussion, treatment negotiations and agreement and any cases of breakdown, tension or trouble in the talk. Making these notes was a useful noticing exercise and enabled analysis to start with a form of 'unmotivated looking' (Sacks, 1984). As another noticing exercise at this stage, I also began transcribing the data without any pre-set ideas about which particular features of talk I would analyse. As described in the previous chapter, these transcript markings follow conventions set by Jefferson (1984) with some subsequent additions and alterations (Heritage and Maynard, 2006c). Due to the large amount of data I had collected, time constraints meant that it was not possible to transcribe all the interactions. Instead, once I had decided what features I wanted to analyse, I focused on transcribing all the relevant sequences in my data. I used the software package Transana to aid with transcription, in particular to measure the length of silences between talk. I also used Adobe Premiere software to edit data clips and create video-still images.

During my initial observations of the video data, I quickly realised that non-vocal/visible actions, such as gaze and the physical position of participants, frequently appeared relevant to the ongoing interaction. Throughout my analysis the video recordings were treated as the data, with the transcripts regarded as the means to represent them in print form (Dingwall and Murphy, 2003). Therefore these non-vocal actions were always observable and able to inform the analysis. However, I

needed to make decisions regarding how and when I would present them in my transcripts. Each area of analysis that I undertook suggested numerous themes to puruse in detail – including non-vocal actions. For reasons of space and clarity I could only select some of these themes to focus on in the thesis. I have chosen to discuss non-vocal actions in sequences where they are central to understanding the unfolding interaction. For example, in chapter 5 I show how the sitting or near-to-sitting position of interactants can be relevant to the hearing of a doctor turn as a potential opening question. Chapter 8 describes how non-vocal actions can enhance the closing relevant sense of a turn and how they may align with a move into closing, in combination with verbal utterances or by themselves. In these types of sequence, the interaction cannot be characterised adequately without reference to non-vocal actions.

In my transcripts I use video-stills to represent these key non-vocal actions. Each still is connected by an arrow to corresponding talk represented in the written transcript. In some instances written descriptions of physical movement, gaze direction etc replace or accompany a video-still. In each video-still the faces of the interactants have been blurred to ensure anonymity. Despite the addition of video-stills, it is recognised that these transcripts cannot represent all the details occurring in the interaction and that they are necessarily selective, aiming to represent those features relevant to sequential analysis (ten Have, 1990).

During analysis I was guided by two research objectives which were designed to be consistent with CA methodology and practice. These were:

To identify the interactional practices used by practitioners and patients during medical treatment for overweight and obesity.

To identify, in particular, interactional practices used by practitioners during sequences that involve verbal patient agreements to undertake changes in treatment.

These objectives emphasise the empirical description and analysis of interaction, to include verbal and non-vocal activities. They are consistent with the CA approach in terms of their focus on action (ahead of subjective 'meaning' or 'understanding') and their inductive element which enables the unmotivated looking at data. The first question in particular is very broad whilst the second topicalises an established theme of CA interest – verbal agreements (see Heritage and Maynard, 2006b). I selected this topic with the aim that my analysis could build on current CA findings whilst also prove relevant to clinical practice and policy. Despite this narrowed focus, the objective is still worded in a way that enables precise analytic themes to emerge from the data.

As far as possible, I selected sequences for analysis through the process of 'unmotivated looking' outlined in chapter 3. This was done through the note-making and initial transcribing described above and enabled me to identify interactional patterns of interest. These patterns included those which were recurrent in the data as well as deviant cases. For example, my interest in doctor solicitations of patient opinion during treatment discussions arose after observing the unusually 'tense' talk between the doctor and 'Rupert' (see chapter 7).

Taking transcripts to data sessions attended by other analysts provided another useful means to identify analytic themes as well as to discuss extracts of interest. In some instances, insights from my previous observational work in the clinics also played a role in selecting what to analyse (see chapter 5 on openings), but it was not assumed that the video data would support my earlier findings.

Once I had selected a type of sequence for analysis, I built up a collection by identifying and transcribing the relevant examples of that sequence in my data. The data were then analysed following the conversation analytic principles set out by Sacks, Schegloff and Jefferson (1974) and described in chapter 3. In accordance with these principles, analysis began with individual cases which were then built up to form an empirical model of the interaction. This model was informed by comparison across cases as well as comparison with existing CA studies and particular attention was paid to deviant cases which did not appear to fit typical patterns. In this way analysis aimed to identify and explain patterns of interaction and to contribute to existing CA knowledge by providing further descriptions of recognised phenomena. Ideally, I also hoped to extend the CA project by describing previously unstudied interactional features or revealing new permutations of those already established. As discussed in the previous chapter, analysis can also reveal how interactants build and maintain an institutional context through their talk (Heritage, 1984). Therefore in my analysis I also paid attention to the relationship between the interactions I was studying and the medical setting in which they occurred.

In relation to the CA debates discussed in the previous chapter, I found it necessary to take a position regarding the use of quantification and wider, 'mainstream' sociology in my work. As noted previously, CA has typically had an uneasy relationship with quantification (Schegloff, 1993). Certainly it is necessary to be cautious over the use of counts and measurements based on categorisations to the neglect of empirical description. Instead, it should be recognised that the persuasiveness of analysis comes from the detailed description of individual cases. Nevertheless, counting and comparing can be analytically useful if the categories used arise from the analysis rather than impose on it. In my analysis I use simple quantification in the form of frequency counts. In each case I outline how the quantification categories were informed by the CA analysis. The counts are used to provide a guide to observable tendencies in my dataset and are not intended to make broader claims about the generalisability (or otherwise) of my findings.

CA also tends to have a difficult relationship with wider sociology, or 'Formal Analysis' (Garfinkel, 1967 and 2002). As discussed in the previous chapter, a 'pure' ethnomethodological approach criticises sociological studies which for rely on concepts and categories that reproduce common sense understandings and typifications rather treating them as topics of study. Despite this, a number of CA and ethnomethodological studies have used this kind of sociology as the starting point for investigation (e.g., Heritage, Robinson, Elliot et al, 2007) or considered how interactional findings may provide empirical evidence of (Toerien and Kitzinger, 2007), or comment on (e.g., Dingwall and Murray, 1983) an established sociological concept. In a similar way this study places itself within wider sociology. In earlier chapters I have reviewed sociological analyses of various issues

connected to obesity, medicine and interaction. Whilst I may not find these analyses totally convincing or agree with their methodological approach, I nonetheless find that they provoke valid sociological questions about these topics and heighten my interest in talk during obesity-related medicine. Therefore, my analysis includes discussion of how my CA findings may mirror, contradict or comment on these kinds of studies. Whilst ethnomethodology and CA may appear to differ greatly from wider sociology, both were developed in response to it. Garfinkel's thought creates a debate with the sociology of Parsons, Durkheim and others, whilst Sacks and Schegloff's interest in conversation arose from their quest for a naturalistic sociological method. I choose to maintain this connection by referring to wider sociological literatures in this thesis. However, this does not imply a distancing from CA's focus on the interaction order as the key domain for analysis. I am aware that the very best CA studies are those that keep interaction at the centre of analysis and only turn to external explanations of what is occurring when none can be found in the talk itself.

4.7: Conclusion

In this chapter I have described how I set about conducting the fieldwork and analysis for this project. In doing so I have represented my research interests as suitable for a conversation analytic approach and my research design as robust. I have also included descriptions of the two fieldwork clinics to inform the analysis by providing key background information. This thesis now turns to the analysis itself.

Chapter 5: Opening questions and Responses

5.1: Introduction

Opening questions from the doctor begin the medical 'business' of the consultation. They solicit information from the patient relevant to his/her medical concerns and reasons for attending. In this chapter, I discuss opening questions and responses in the Diabetes and Obesity Clinic (DOC) and the Weight Management Clinic (WMC). My findings show that the doctor typically asks a "how are you?" type question and that patients respond with talk relevant to the medical context. Analysis also reveals that patients' responses can be heard to imply success or lack of success in weight loss progress.

When producing these different responses, patients invoke their personal agency in different ways. 'Successful' patients emphasise their agency in relation to treatment behaviours leading to positive news about weight loss, diet, exercise health improvements etc. By contrast, 'unsuccessful' patients minimise their agency and emphasise that unwanted constraints have limited their treatment efforts. Both 'successful' and 'unsuccessful' patients present themselves as knowledgeable about their condition and as making an effort to become 'well'. Through their responses, patients can be seen to invoke normative issues of knowledge, responsibility and effort in connection to obesity management and patienthood. This is made possible by the non-constraining form of the doctor's opening questions and subsequent turns which encourage patient talk to continue. In this way,

the doctor and patient collaboratively construct obesity as a simultaneous medical and moral concern.

5.2: Analysing opening questions and responses

In a typical medical consultation (ten Have, 1989; see chapters 3 and 4), initial greetings are followed by a question from the practitioner, which functions to solicit information from the patient about his/her condition. This question initiates the start of the medical 'business' of the encounter and can be described as an opening question. Opening questions and responses have been studied in various CA analyses. Heritage and Robinson (2006: p. 90) write that they represent "the only phase of medical visits in which patients are systematically given institutional licence to describe their illness in their own terms and in pursuit of their own agenda". They offer a very fruitful area for analysis, enabling investigation of how patients talk about their condition and what additional concerns they present when doing so.

The extent to which patients can talk in their own terms may be constrained by the wording of the opening question asked. In an analysis of US and UK primary care visits, Robinson (2006) notes that opening questions solicit information from the patient whilst also displaying the practitioner's 'state of knowledge' about the meeting. That is, whether it is about a new problem presented by the patient for the first time, a follow-up encounter concerning a previously presented problem or a routine appointment about a chronic condition. Practitioners may reference the different aims of these consultations in their opening questions and so project a framework for the patient to answer within. In new problem consultations, opening questions such

as "What can I do for you today?" and "How can I help you?" solicit the patient's presenting concern and display that the practitioner has no present knowledge of what the patient has come to talk about. In follow-up consultations, the opening question may display the practitioner's assumption that the patient has news to report on an existing condition with questions such as "How have you been?" or more explicitly, "How is your knee?" etc. In routine consultations the practitioner may also express knowledge of the patient's condition and reasons for visiting. Robinson gives the example (perhaps more common to American than British English) of "What's new?". The temporal element in the question acknowledges the long-term status of the condition and suggests that the patient may have something new to report. Whilst many opening questions mark the particular format of the consultation in this way, others do not. Robinson cites "How are you?" as one example. "How are you?" is often produced at the start of talk as a general enquiry (Jefferson, 1980), but as a medical opening question it functions to solicit an evaluation, progress report or update from the patient. It does not mark any specific time frame or health problem to be referred to so it is particularly non-constraining, whilst also suited to various kinds of consultation.

Garafanga and Britten (2003) note that the practitioner's question alone does not determine the format of the consultation. Instead, it is jointly established by practitioner and patient through interaction. The practitioner's expressed 'state of knowledge' about the type of consultation occurring is confirmed or disconfirmed by the patient's response. If the patient responds to "How can I help you?" with talk about a new concern, this collaboratively establishes the consultation as a new problem meeting. Alternatively, if the practitioner asks a

question that assumes the patient is visiting about a new problem and the patient answers in terms of an existing one, this lack of fit needs to be dealt with in the following talk to enable the consultation to progress.

In addition to confirming or disconfirming the type of consultation occurring, patients' responses to opening questions provide information about their medical concerns. A number of CA studies have investigated how patients present their problems in primary care, for example as narratives of symptom discovery (Halkowski, 2006), as routine conditions that they 'know' about (Heritage and Robinson, 2006) or unknown symptoms that they have nonetheless come to realise require medical attention (Heritage and Robinson, 2006). Heritage (in press) argues that opening question responses often work to legitimate the patient's medical attendance. "By the very fact of making the appointment and walking into the physician's office" (p. 3), patients assert the existence of a problem which they cannot deal with alone and which must be handled by medical experts. A pressing task for patients in the consultation is to defend these assertions by showing that their problem is indeed 'doctorable'. Responding to opening questions provides an opportunity for patients to do this work. Heritage observes that patients frequently design their responses to defend their decision to attend as properly motivated by health concerns. This enables patients to present themselves as in the sick role and taking appropriate steps to exit it by seeking expert help (Parsons, 1951 and 1975). Devices employed include references to past medical history or third party advice to seek medical help. The doctor's response is crucial in establishing or rejecting the legitimacy of the presented problem.

CA work on responses to opening questions has tended to focus on new problem consultations in primary care. My data concern routine appointments in secondary care and it is likely that patients' responses will perform different functions to those discussed above. Significantly, the patients in my data have already been given a diagnosis and attend appointments as a matter of course. They are not required to justify their reasons to attend or display that they are appropriately 'sick'. Instead, the aim of the encounter is to enable the patient's health status to improve so that it becomes manageable, if not 'cured'. Patients who make no progress over time may be at risk of being discharged as a 'hopeless case'. Is it possible that talk in opening sequences may orient to these features, and, if so, how? Another potential theme for analysis concerns how patients talk about their treatment behaviours between appointments, such as lifestyle changes associated with diet and exercise. Drew (1998) writes that when we describe our own (or others') behaviours we design our talk to display the appropriateness or inappropriateness of that behaviour. We select from a range of possible modes of description and our talk "may always and irretrievably be understood as doing moral work – as providing a basis for evaluating the "rightness" or "wrongness" of whatever is being reported." (p. 295). Patient answers to opening questions may therefore perform moral work and analysis can identify which particular normative concerns they invoke.

5.3: Openings in the WMC and DOC

By the time I came to analyse my data recordings I was already interested in the opening phase of consultations. I had noticed two features of interest during my observations in the clinics and my initial

reviews of the recordings. Firstly, I noticed that opening questions in both the WMC and the DOC were almost always worded in a general form, for example, "How are you?" and "How have you been?". Although these questions shared the wording of general enquiries, it was 'obvious' to me as an observer that they sought information related to medical rather than general matters. This function also appeared 'obvious' to the patients, who responded with talk relevant to their health status. I wanted to analyse how these questions were hearable as opening questions and to consider why they might take this kind of wording.

Secondly, I was interested in the answers patients produced, in particular how they foreshadowed issues of success and lack of success in weight loss progress. When observing, I found that I was able to predict whether or not patients had achieved weight loss before they stood on the scales (WMC) or their weight record was read out by the doctor (DOC). This prediction was based solely on the ways patients responded to the opening question and was consistently correct, whether or not the patient had even mentioned weight. I was keen to analyse patients' opening responses further to identify which interactional features enabled me to make these predictions.

I watched all 39 recorded consultations and noted how the opening phase proceeded. For the purposes of analysis, I disregarded five cases as not relevant to my specific interest in how opening questions were asked and answered. In one case the camera was not turned on in time and in the other four opening questions were not asked: once (in the DOC) because the patient was complaining of a hypo-glycaemic attack so the start of the consultation was taken up with immediate

treatment; once because the patient was attending for the first time; and twice because patients produced relevant medical information without an apparent opening question being asked. I transcribed the remaining 34 cases and analysed them sequentially. The major analytic findings are presented in this chapter and the complete transcripts are in appendix B. In some cases, the transcript begins with the start of the consultation and in others it begins with the opening question. Where line numbers in chapter extracts begin after 1, this indicates that corresponding transcripts in the appendix show some earlier talk. Transcripts in the appendix may also extend beyond the talk presented here. I include a page reference in brackets next to each extract heading, showing where the transcript can found in appendix B.

I begin by discussing how the doctor and patient accomplish opening questions and responses. I describe the interactional features which produce a hearable opening question and show how patients treat them as such by producing medically relevant responses that accomplish the start of the consultation. I then discuss the ways patients' answers can be hearable as implying success or lack of success in weight loss progress and note a pattern that can be observed in these different types of answer. Patients implying success tend to enhance their personal agency when talking about the treatment behaviours of diet, exercise, health improvements etc that can be connected to weight loss. By contrast, patients implying lack of success tend to minimise their agency in relation to treatment behaviours associated with weight gain and often report the existence of constraints on their efforts to get better. I argue that, along with displays of knowledge and effort consistent across all answers, these alternate responses invoke a range of moral concerns connected to the medical encounter.

5.4: Findings

5.4.1: Accomplishing opening questions and responses

This section describes how the doctor and patient collaboratively accomplish opening questions and responses. I present four extracts covering the start of the consultation until the first part of the patient's opening question response. I focus on discussing how the doctor's talk is hearable as an opening question and how patients treat it as such by delivering responses relevant to the medical encounter.

Turn hearable as an opening question	Number of cases
Turns with wording similar to general enquiries.	23
How are you feeling?	1
Questions/turns that reference previous talk.	4
'You're looking well.'	2
More than one possible opening question.	4
Total	**34**

Table 5.1: Table showing the frequency of different doctor turns treated by patients as opening questions

Table 5.1 shows the frequency of different turns in the data treated by patients as opening questions. In most cases, the doctor produces a single turn that (through features of delivery, see below) is hearable as

a potential opening question and is responded to as such by the patient in the following turn. However, in four cases one or more potential opening questions were observed. In the single turn cases most opening questions shared their wording with general enquiries common to greeting sequences (23 out of 34 cases). In seven other cases the wording of the opening question took a different form: one "How are you feeling?"[5] and four turns that referenced some prior talk or event. There were also two 'deviant' cases in which the possible compliment (see chapter 6) "you're looking well" was responded to with information relevant to the consultation.

Opening question with wording similar to a general enquiry	Number of cases
How are you?	17
How's life?	1
How are things going?	1
How are things?	1
How are you doing?	3
Total	**23**

Table 5.2: Table showing the frequency of different opening questions with wording similar to a general enquiry.

Table 5.2, above, shows the different types of opening questions asked with a wording similar to a general enquiry. "How are you?" is by far the most common question (17 cases). As shown in extracts 1 and 2,

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[5] Although this could be seen as another question sharing wording with a general enquiry, I have placed it in a separate category following Robinson (2006), who argues that in a clinical setting "feeling" marks a bio-medical interest. Therefore "How are you feeling" can be heard to topicalise medical matters specifically.

"How are you?" is delivered in ways that distinguish it from general enquiries and suggest its relevance to the medical context.

Extract 1: Becky WMC 25th Oct (pp. 10-12 in appendix B)

This patient attends with her mother.

```
1.   Doc:    Right. [Hi:
2.   Mum:          [Candid came[ra now
3.   Pat:                      [Hiya y'alright?
```

↓


```
4.   Mum:    huhuh hi[ya
5.   Doc:            [Hello.
6.   Mum:    .HHH uhh
7.           (2.0)
8.   Doc:    Now I can't find the la:-cos we've met
9.           befo::re, but I [can't but I can't I can't
10.  Pat:                    [we ave
11.  Doc:    find the letter .hh from when we met
12.          befo:re
13.          (1.7)
14.          which iz uh rather frustrating (problem)
15.          (.)
```

```
16.              for [me)

17.   Pat:          [I bin to Cleedon since

18.   Doc:     Aaa::h. Right.

19.   Pat:     [So has it gone there?

20.   Doc:     [(D'you)

21.              (.)

22.    Doc:    U::m (0.2) shouldn't uv done, because we

23.              run our suh- own set of notes independent

24.              of Cleedon [>but anyway< (.) doesn't

25.   Pat:                   [Ri::ght.

26.   Doc:     matter. **How are you?**
```



```
27.              (0.6)

28.   Pat:     I'm alri:gh, I tri:ed the Xenical
```

The talk begins with general greetings in lines 1-5. In the silence in line 7 the doctor walks towards his desk and in line 8 begins to explain that he can't find the notes about the patient's last consultation. In line 17 the patient reports that she has been to Cleedon – indicating another hospital in the region (where she has just been placed on a waiting list for bariatric surgery). In line 19 she asks if the notes have gone there and in lines 22-24 the doctor states that this shouldn't have happened and explains why. In lines 24 and 26 the doctor changes topic within

his own turn: ">but anyway< (.) it doesn't matter. <u>How</u> are you?" The "<u>How</u> are you?" comes well after the interaction has started, not the normal place for a general enquiry question, which would usually be produced nearer the start of talk (Jefferson, 1980). The "but anyway< it doesn't matter" preceding the question has the effect of clearing away what was said before as no longer relevant and indicating that a new topic is about to be introduced. This is enhanced by the downward, finishing intonation at the end of "matter". Meanwhile, the increased volume at the start of "<u>How</u> are you" marks the newness of the topic. As the question is delivered, the doctor, patient and her mother are all sitting. Their physical positions suggest they are ready for the business of the consultation to begin (Heath, 1986) and the doctor's gaze, directed towards the patient, indicates that he is ready to receive her opening concerns (Robinson, 1998).

In line 28 the patient begins her answer with "I'm alri<u>:</u>gh,". This is the kind of general, neutral response that typically follows a general enquiry (Jefferson 1980) but it could also be heard as an evaluation of her biomedical status. The patient continues with a reference to trying Xenical, a weight loss drug. By going on to produce more than a generic response, she displays that she has heard the question as different to a general enquiry and by referencing a weight loss drug she fits her response to the medical context. Her reference to "the <u>Xe</u>nical", rather than just "<u>Xe</u>nical", indicates that the topic of taking this drug is known to both doctor and patient, so has been previously discussed – presumably in a previous consultation. In this way, her talk marks the current consultation as one in a series, and constructs it as a routine encounter.

It is noticeable that although the doctor's question did not reference obesity or weight loss, the patient's answer treats it as enquiring about these matters. The patient appears to draw on the context of the talk to interpret the question as asking about issues relevant to the consultation. It is also noticeable that the patient has already supplied a possible presenting topic, her consultation at Cleedon. The doctor could ask about this; however he asks the more general question.

The late position of "<u>Ho</u>w are you?" plus its prefacing and increased volume suggest that it is being used to open up a new, context-relevant topic. As such it is hearable as an opening question. The patient treats it as an opening question with an extended response and information report relevant to the consultation. The same pattern is found in extract 2.

Extract 2: Rupert DOC 14th Nov (pp. 16-17 in appendix B)

This patient attends alone but a medical student in also in the room.

```
1.  Doc:    Do have a se[at.
2.  Pat:              [Fi:nally huhuh .HEe
3.          (0.9)
4.  Doc:    Sorry for the wait
5.  Pat:    Not a pro:blem
6.          (0.8)
7.  Doc:    We:lcome ba:ck it's nice to [see you
8.  Pat:                                [.hhh
9.  Pat:    Ahh
10.         (0.4)
11. Pat:    How you doing?
```

```
12. Doc:    I'm goo:d °thank you° I'm good. THis is
13.         Linda who's one of our medical students =
14. Stu:    =Hello there
15. Doc:    Wou:ld it be alri:ght if she sat in [(   )
16. Pat:                                       [No
17.         problem
18. Doc:    Do have a seat
19.         (1.4)
20. Doc:    So::. (1.3) How uh you?
21. Pat:    .hhh
22.         (1.3)
```

↓   ↓
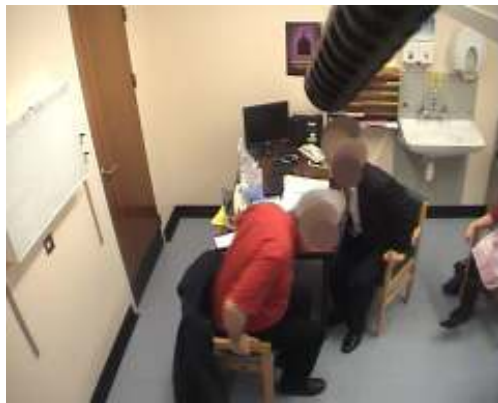

```
23. Pat:    Okay,(.) my knee is no:w (1.5) ninety five
            ↓
```



```
24.         per cent be:tter
```

The consultation begins with opening greetings and talk about waiting time (lines 1-12). The greetings include a general enquiry (line 11) from the patient which is answered by the doctor in line 12, but not reciprocated. The doctor then introduces the medical student and after the patient has consented to the student remaining in the room, the doctor invites the patient to sit down. In line 20 the doctor says "So:::. (1.3) How uh you?" (line 20). At the start of the turn the doctor is standing by his chair and as he produces the second part of the question he sits down. The prefacing of the question with a sound-stretched and emphasised "So:::." marks the enquiry that follows as a matter of ongoing concern (Bolden, 2006). It indicates that the question relates to specific, unfinished business between the interactants – e.g., the patient's medical problems - and invites an expanded response.

Following a silence in which he adjusts his chair, the patient begins his response in line 23 with "Okay,". This could be a generic general enquiry response or an evaluation of his medical status. However, its enhanced delivery and continuing intonation suggest it announces the onset of more talk. The patient reports some news about his knee (lines 23-24), describing it as "ninety five per cent be:tter". This report is hearable as connected to the medical context in general and obesity management in particular. It suggests medically relevant progress which may be a product of weight loss as well as an opportunity for increased physical exertion enabling weight loss. The use of the comparative "be:tter" indicates (positive) change over time and between appointments. As in extract 1, the patient's answer can be seen to construct the current consultation as one in a (routine) series. Additionally, the patient here also appears to draw on the context of

the consultation to interpret the non-specific wording of the doctor's question.

As in extract 1, the "how uh you" is delivered well after the start of talk, once some 'small talk' has already occurred. In this example the patient is sitting and the doctor is standing by his chair when the question is asked, indicating readiness and near-to-readiness for the consultation to begin. In this case a general enquiry question has already been asked by the patient but not reciprocated by the doctor. It is useful to consider that if the doctor produced his subsequent "how uh you" immediately after his response to the patient's enquiry (i.e., line 12), it would have a very different hearing in terms of the action it performed in the consultation. Instead it is produced after introducing the medical student and inviting the patient to sit down – both typical activities for the start of a consultation. By being produced in a different sequential positon to general greetings, the question does some other business than making a general enquiry. By producing a response reporting relevant medical progress the patient treats it as an opening question.

In extracts 1 and 2 "How are you?" is hearable as an opening question due to: its delayed delivery until after general greetings and other introductory sequences have been completed; its marking as referencing a new topic through intonation, increased volume and prefacing; and its delivery when the patient is sitting and the doctor is sitting/in the process of sitting, suggesting the relevance of the start of the consultation. In response the patient treats the turn as an opening question by answering with medically relevant information. The occurrence of most or all of these features is common across the "How

are you?" and other general enquiry type questions in the data, producing hearable opening questions that solicit a progress report, evaluation or update from the patient. They are also observable in the (single turn) opening questions that take a different form. Extract 3 is an example of an opening question that references prior talk.

Extract 3: Ian WMC 13th Dec (pp. 42-43)

```
1.   Pat:     [Hello.
2.   Doc:     [Alright Mr Graham, nice to see you agai:n
3.            (0.6)
4.   Pat:     Yes .hhh
5.            (0.4)
6.   Doc:     Welcome ba:ck
7.   Pat:     Yeh .hhh long ti:me, seems a long
```



```
                   ↑
8.   Pat:     time.
9.            (0.8)
```

↑

```
10.  Doc:      So how uv things bin since (.) last time

11.            you came?

12.  Pat:      U::m (.) I've put weight on, cos I've bin

13.            inactive

14.            (.)

15.  Pat:       cos I've ad [me knee done.

16.  Doc:                   [the knee
```

After initial greetings, the doctor comments, "Welcome back" in line 6. The patient responds "yeh .hhh hh long ti:me, seems a long time" whilst moving towards a chair and sitting down. The "yeh" connects his turn to the doctor's talk so that the "long ti:me, seems a long time." is also hearable as referencing coming back to the clinic. The "seems a long time", implies the first part of a grammatical structure to be completed with "since I saw you", "since I came here" etc. In line 9 the doctor sits down then takes a turn that reformulates the implied part of the patient's response and includes it in a question: "So how uv things bin since (.) last time you came?" (lines 10-11). Again the "so" preface suggests that the question addresses a matter of ongoing concern and invites an expanded response. The "how uv things bin" solicits general

information but the "since (.) last time you came?" marks an interest in the period of time between consultations and the physical setting of the clinic. The question therefore functions to solicit information about the patient relevant to his continued attendance at the clinic. In response the patient reports weight gain and attributes it to certain factors. The information about weight gain is hearably relevant to the business of the WMC. The patient's use of the present perfect ("I've put weight on,") mirrors the design of the doctor's question and displays that he is answering with reference to the suggested time scale (and by extension, in reference to the same physical place) whilst also suggesting that this weight gain is relevant to today's encounter.

The doctor's question is a potential opening question and is hearably formed through the patient's previous reference to "long ti:me". The reference to the clinic and a particular time frame makes it more constraining than "How are you?" and this is shown in the patient's response which mirrors doctor's grammatical construction. Once again, the hearing of the turn as an opening question is enhanced by its delayed sequential position after small talk, "so" prefacing and the physical positions of the doctor and patient. The patient's response treats it as an opening question by topicalising weight.

These three extracts demonstrate that, despite differences in wording, doctor turns are hearable as opening questions through similarities in their delivery. This pattern of delivery is consistent across the data. It does not mean that all the features occur in each case but that in any given example most of them do appear. In four cases the doctor appeared to ask more than one potential opening question, sometimes appearing to treat the patient's intial response as proving 'small talk'

rather than medically relevant information. In these cases, some of the features described above tended to be absent. For example, the doctor and patient were still standing when the question was produced or little previous talk had occurred (see appendix B pp. 46-52).

These extracts also show similarities in how patients construct their replies as opening question responses. They draw on the context of the talk to report medically relevant information. This information typically refers to status of treatment behaviours, such as taking drugs (extract 1), doing exercise (extract 2) or other medical concerns (extract 3). The information giving is sometimes prefaced by a short assessment, e.g. "I'm alrigh" in extract 1. In a few cases the patients responded to the opening question with an assessment only. The construction of these assessments often hints at medically relevant information to follow, so can be heard as a kind of opening question response. This is shown in extract 4.

Extract 4: David WMC 13th June (p. 30 in appendix B)

```
1.   Doc:      How are you?
2.   Pat:      Not so bad, thanks
3.             (1.4) ((Doc sits down))
4.   Pat:      been BE:tter but,
5.   Doc:      What ur yuh-umm what's happening at
6.             moment
```

The doctor asks "How are you?" in line 1 and the patient begins his response in line 2. His "Not so bad, thanks" provides an evaluation that is slightly downgraded from the "fine" type comment that Jefferson

cites as the conventional, neutral response typical to general enquiries. In providing this downgraded response, the patient appears to do something in addition to answering a general enquiry. Jefferson (1980) observes that downgraded responses such as "not so bad" and "pretty good" can project that the speaker has a trouble he/she may report on at some later point in the talk. Whilst it is not always the case that the speaker will deliver a report, a downgraded response suggests that this is a possibility, whereas a conventional "fine" type response does not. Here the patient's response suggests there may be a relevant "trouble" report to follow. This is enhanced by his continued evaluation, "been BE:tter but," in line 4. This further downgrading, combined with continuing intonation, emphasises the possibility of (bad) news to follow. The "BE:tter" invokes a possible biomedical sense to his talk and suggests that any subsequent news may be relevant to the medical context. With this response the patient appears to premonitor, but delay, a medically relevant troubles-telling (Jefferson and Lee, 1981). This indicates that he is treating the doctor's turn as an opening question. In response the doctor solicits further information.

Patient responses to opening questions take the form of information reports and/or assessments relevant to their treatment status between appointments. The responses are typically fitted to the doctor's prior question and provide answers relevant to the start of a routine medical consultation. The start of the consultation is therefore accomplished collaboratively. The answers given by patients vary according to topic and are designed in different ways. This variation is fitted to, and enabled by, the wording of the opening questions. In most cases, the doctor's question solicits talk relevant to the medical setting but does not select any particular topic for the patient to refer to, or express any

assumptions about his/her health status. Patients are able to select how to construct their answers in terms of length, information reported, actions performed and so on.

As I discuss next, this non-constraining form also enables patients to invoke a variety of other issues in their responses. I show that patients' answers can typically be heard to imply either success or lack of success in weight loss progress. It is possible to observe a key difference in the ways 'successful' and 'unsuccessful' patients construct their agency in these answers, particularly in reference to their own treatment behaviours. Whilst 'successful' patients enhance their agency, 'unsuccessful' ones minimise it. Across both types of answer, patients also demonstrate knowledge of their condition and efforts to become well. Through their talk patients can be seen to invoke normative issues connected to weight and patienthood, and to perform moral work. The doctor's opening questions and further talk play a key role in enabling these responses to unfold.

5.4.2: The answers: implying success and lack of success

In this section, I discuss patient answers to opening questions in more detail. I begin by describing answers that can be seen to imply success in weight loss progress. I show that in these responses, patients enhance their own agency in relation to their reported treatment behaviours. I then contrast this with answers hearable as implying lack of success and show that here patients tend to minimise their agency. Across cases, patients also design their answers to display a willingness to make an effort and become well. Interactional features including the 'choice' of information reported and the order in which it is given,

patient self-assessments, length of response and the 'shrouding' of bad news are all relevant to how these answers, and the moral work performed in them, are produced.

Implying success

Extracts 5 and 6 are typical examples of opening question responses that can be heard to imply success in weight loss. In extract 5, the patient produces a series of positive information reports about his treatment behaviours in which his personal agency is enhanced.

Extract 5: Rupert DOC 14th Nov (pp. 16-17 in appendix B)

```
20. Doc:      So::. (1.3) How uh you?
21. Pat:      .hhh
22.           (1.3)
23. Pat:      Okay,(.) my knee is no:w (1.5) ninety
24.           five per cent be:tter
25.           (0.3)
26. Doc:      Okay.
27. Pat:      °er°I've avoided having any operations on
28.           it, so suh .hh that's good
29. Doc      Ptch °yes°
30. Pat:      um .hh I sta:rted the swimming
31.           (0.4)
32. Doc:      Grea:t
33. Pat:      .hh I went twice
34.           (0.3)
35. Pat:      and then I was told by: .hh er °um°
36.           the guy at thuh City to stop because both
```

```
37.              times my knee (0.6) swelled u:p
38. Doc:         Right. You set off your knee.
39. Pat:         Yeah a:nd he said=
40. Doc:         =°Okay°
41. Pat;         thut what's proble:y (0.6) happening wuz
42.              it wuz actually over extending,
43. Doc:         °Right.°
44. Pat:         °Right° .hhh so: I've stopped that, but
45.              I've been goi:ng to the gy:m,
46. Doc:         ↑Oh grea:t
```

This extract continues from extract 2. As noted above, the patient's response to the doctor's opening question begins with "Okay," followed by a news report about his knee. This is a positive report indicating that medical progress relevant to weight has been made and therefore can be heard to imply success.

In line 26 the doctor produces a continuer "okay", which encourages the patient to go on with his talk. In line 27 the patient says: "I've avoided having any operations on it,". The verb "avoided" conveys that the action it is connected to, having an operation, is less than favourable, so here the patient implies more success. "I've avoided" positions the patient as the grammatical subject of the talk and therefore the agent of this success. An operation is usually something serious and medically necessary, so by crediting himself in this way the patient makes strong claims about his actions. In line 28 he assesses this news: "so that-that's good" making explicit that he is treating it as positive. This positions him as aware of what is medically 'good' for him and as capable of assessing his own illness experience (Gill, 1998).

In line 29 the doctor produces a quiet and minimal agreement, "°yes°", and in line 30 the patient begins a new topic with: "um I sta:rted the swimming". As it refers to exercise behaviours, this talk is also relevant to weight loss and can be seen as a continuation of his opening question response. The use of "the swimming", rather than just "swimming", displays that this activity has been discussed by the doctor and patient previously. In addition to orienting to the consultation as one in a series, this reference implies that the patient has listened to medical advice and taken action on it, meaning he is compliant and willing to make an effort. However, the "started" in the past simple (compared, for example, to "I have started") implies that the activity was not successful and has been stopped. After a positive comment from the doctor in line 32, the patient explains why he stopped swimming from lines 33 to 42. He reports it as something he was told rather than chose to do (line 35), positioning stopping as beyond his control. Furthermore, he was told this by "the guy at city" (line 36), meaning a practitioner at another local hospital and therefore a legitimate source of medical advice. The addition of that practitioner's observation about the knee over-extending (line 42) justifies the stopping as medically necessary and again displays that the patient listens to medical advice. In lines 44-45 he concludes with "so I've stopped that, but I've been goi:ng to the gy:m". The report of the 'failure' – stopping swimming – is immediately offset by positive news about gym visits and further evidence that the patient is making an effort to lose weight. In fact by reporting the failed difficulties caused by swimming first, the patient indicates that his efforts include overcoming obstacles.

The doctor responds in lines 46 with "↑Oh great". The "Oh" functions as a change of state token acknowledging new information (Heritage, 1984a) and the "grea:t" provides a positive comment on it. This displays a positive orientation to the patient's efforts to continue exercising despite having to stop the swimming. It is noticeable that in his responses during this sequence, the doctor does not overtly accept or challenge the patient's claims. For example, he could query whether the practitioner who advised the patient not to swim might have included the gym as a similar activity that could overextend his knee. Instead, the neutral/positive valence of his talk jointly constructs the patient's answer as implying success.

Extract 6 further demonstrates how patients imply success in their responses. The patient produces a series of positive assessments followed by an information report that emphasises his continued exercise.

Extract 6: Timothy WMC 25th Oct (pp. 39-40 in appendix B)

```
17.  Doc:      How're you feeling?
18.  Pat:      Brilliant. Brilliant.
19.             (0.4)
20.  Pat:      Excellent hh I'm I'm
21.             still going to the gym, un
22.  Doc:      You've lost weight haven't you?
```

The doctor's "How're you feeling?" in line 17 shares the features of delivery observed in the previous section, so is hearable as an opening question. In line 18 the patient begins his answer with "Brilliant.

Brilliant." The doctor does not take a turn following this and the patient selects to speak again in line 20: "Excellent". These strongly positive assessments are outside the neutral range of responses that normally follow a general enquiry (Jefferson, 1980), suggesting that they relate to a more specifically biomedical sense of "feeling" (Robinson, 2006). This sense is enhanced by the extended answer the patient produces in lines 20-21, reporting that he is still going to the gym. This information implies efforts to become fit and lose weight through exercise and is therefore relevant to the medical context. By reporting them here, the patient implies that the gym visits are the reason for his previous positive assessments. In combination, the two parts of his response suggest that his gym visits, and by extension his weight loss efforts, have been successful. The patient's answer also emphasises that this success is the result of his own activity. This is achieved through the repeated "I'm" in line 20 and in particular the use of "still", in line 21, which displays that the gym work has been continuing for some time, indicating a continued effort. In line 22 the doctor asks "you've lost weight haven't you?". This topicalises weight and suggests that the doctor is treating the patient's prior talk as relating to his weight status. The talk is constructed as an observation, "you've lost weight" followed by a confirmation-soliciting tag question, "haven't you?" It draws out the implications of the patient's answer and implicitly affiliates with the positive slant of his talk. The question tag provides an opportunity for the patient to agree and (as in line 19) produce further talk on the topic.

These two extracts demonstrate the typical features of opening question responses that can be heard to imply success in weight loss progress. Success is implied through positive assessments and

information reports about various treatment behaviours connected to weight loss, such as diet and exercise (extracts 5 and 6), health improvements (extract 5), weight records (extract 7, below) etc. Patients emphasise their own agency in the achievement of these positive behaviours. They highlight their role in what can be seen in the medical context as 'creditworthy' actions. In addition, patients present themselves as knowledgeable about their condition and as making an effort to become well. These references perform moral work, in which patients construct their behaviours as normatively 'good'.

This pattern has some similarities with Maynard's (2003) observations on news delivery in various interactional settings. Maynard argues that 'good news' tellers tend to present news as their own accomplishment and emphasise their agency in connection to what can be normatively understood as creditworthy actions. (In doing so, their talk may create a 'compliment soliciting environment', making relevant a positive response from the next speaker.) This is seen in my data in the ways patients report their own positive treatment behaviours.

Maynard also observes that good news tellers tend to report their news quickly, whilst bad news tellers tend to delay it. This is not always the case in my data; for example in extract 5, there is a 1.3 second pause before the patient begins his response. However, delays in producing a response – through pausing and hinting at news rather than reporting it explicitly – are far more frequent when the patient implies lack of success rather than success. It is possible that the interactional phenomenon of the immediate reporting of good news is relevant to extract 7, in which the patient begins an answer to the opening question whilst it is still being delivered.

Extract 7: Jim WMC 8th Nov (pp. 31-33 appendix B)

```
16.  Doc:      .hh So:? [how're you doing?]

17.  Pat:              [O  K  A  :  :  Y ]

18.            (0.5)

                      ↓
```



```
19.  Pat:      This mor::ning (.) I stood on the

20.            sca::le, I was just under

21.            two .hhh oh six.

22.  Doc:      Oka:y?

23.  Pat:      Yup

24.  Doc:      Last time you came you we::re two one

25.            three:?

26.  Pat:      Yeh

27.            (.)

28.  Doc:      Two oh six without any clothes

29.            on nothing.

30.  Doc:      And you'd [gone down a couple uv-

31.  Pat:               [It was just uv

32.  Doc:      a couple of clothes sizes last time

33.            hadn't you?

34.  Pat:      I'd uh and again
```

In line 16 the doctor asks: "hh So:? how're you doing?", which is hearable as an opening question in this context. Following the doctor's sound-stretched "So:?", the patient begins a turn in overlap: "OKA::Y", (line 17). The "OKA::Y", produced with enhanced volume, does not appear to respond to anything prior and is hearable as announcing the onset of some further talk. In the pause in line 18, the doctor sits down. The patient starts speaking again when the doctor is in his chair with his gaze now directed towards him (Robinson, 1998). In lines 19-21, he reports his weight status that morning. As this talk relates to weight, it is hearable as providing the type of information typically found in an opening question response. It is also hearable as providing the information giving projected by the "OKA::Y".

With this talk, the patient appears to begin an opening question response before the question itself has been delivered. It is possible that the patient has identified – through features of the unfolding of the talk – an interactional 'space' in which an opening question and response are hearably relevant.

There are features of this unprompted, immediate talk about his weight which suggest that the patient is implying success rather than lack of success. In lines 19-20 he says, "this mor::ning (.) I stood on the sca::le,". The "I stood on the sca::le," is not grammatically necessary for this turn structure but its inclusion emphasises the patient's own action of weighing himself. He continues: "I was just under two .hhh oh six." His omission of the unit of measurement (kilograms) in this weight report treats the technical details as straightforwardly knowable to the doctor and himself. He does not orient to this weight as a loss or gain. However, the reference to "just under" can be heard to emphasise the

lowness rather than highness of the number to suggest a (creditworthy) loss. This sense is enhanced by the patient's straightforward response to the doctor's subsequent question (lines 22-23). The talk from lines 24-34 confirms that the patient is reporting weight loss. As in previous examples, the patient can be seen to enhance his agency in his talk. The inclusion of "I stood" in line 19 suggests that the credit for having current information and, by extension for successful weight loss, lies with the patient. It is possible that the starting of his answer before the question has been asked is connected to the 'good news' content of the talk. In my data there are no examples of patients pre-empting an opening question in this way with an answer that replies lack of success. However, there are several examples of patients delaying such responses.

Finally in this section, extract 8 illustrates the constancy with which patients emphasise their own agency when implying success. Here the doctor produces a possible compliment on the patient's appearance and the patient responds with information relevant to the consultation. As a compliment, the doctor's turn places particular (preference) constraints on her answer but her response is designed to fit those constraints whilst also emphasising her agency.

Extract 8: Miriam WMC 8th Nov (pp. 40-41 appendix B)

↑

```
6.   Doc:    You're looking very we:ll:

7.   Pat:    Ye:s, I think I've done alright since I

8.           last saw you,

9.   Doc:    mmm[::.

10.  Pat:       [.hh Bin (1.3) in contro:l, but u:m .hh

11.          I adopted a geriatric basset hound ence

12.          the: (.) [hairs everywhere .hhh

13.  Doc:             [°huhuh°

14.  Doc:    huhuh [right.

15.  Pat:          [And I've managed to tuh walk him

16.          .hh fer an hour at a snail's pace twice a

17.          day.
```

The doctor's turn takes the grammatical and lexical form of an assessment/compliment (see chapter 6). It credits the patient for a positive appearance. In this setting the reference to 'looking well' can be heard to imply an improvement in health through weight loss and as such the doctor appears to assume patient success. The delivery of the turn shares the features of opening question delivery described above. It follows a period of 'small talk' and a silence in which the doctor

moves over to his chair (see appendix B pp. 40-41). The patient is already sitting and the doctor directs his gaze towards her. The "You're looking very we:ll:" therefore appears to mark the start of a new topic and refer to a specific, biomedical concept of wellness. As an assessment the turn invites the patient to produce an agreeing second assessment on the same topic (Pomerantz, 1984a) and therefore can be heard to solicit information relevant to the encounter. As a possible compliment (Pomerantz, 1978; see chapter 6) it also prefers a downgraded response that avoids self-praise. By preferring two kinds of response and specifying a topic (wellness) for the patient to respond to, this is a particularly constraining turn.

The patient responds with an immediate agreement "Ye:s." followed by a second assessment, "I think I've done alright since I last saw you," (lines 7-8). This is hearable as commenting on her progress between consultations and therefore provides information relevant to the consultation whilst also performing the conditionally relevant second assessment. The "I think" qualifies the positive assessment as her personal, non-expert, opinion whilst the "done alright" reformulates the doctor's "looking very we:ll:" and gives it a 'diluted' sense (see chapter 6). The patient then extends her answer. This provides information relevant to the consultation in ways also produced in response to opening questions. After a doctor continuer in line 9, she says "Bin (1.3) in contro:l,". As it immediately follows her reference to doing well between consultations, this talk is hearable as providing medically relevant information. It implies that managing her own (health) behaviour is key to doing well and so provides evidence to support her assessment whilst also emphasising her own agency and implying sucess. The patient then reports adopting and walking a dog. The "but"

in line 5 suggests it starts a new topic from being in control, but as evidence of consistent exercise it also implies further success. The "I've managed" and "snail's pace" in lines 15 and 16 limit the strength of this positive report and avoid self-praise in a way consistent with compliment responses. However, "I've managed" also implies achievement despite difficulties and therefore emphasises the patient's agency and effort; its formation in the present perfect also displays that this achievement has been ongoing over a period of time. The patient's effort and agency are also enhanced by the "an hour… twice a day" indicating the frequency and length of her activities.

In this extract the doctor's apparent compliment assumes (visual) patient success in a way that draws on the particular context of the medical obesity setting. In response the patient does not have to perform the 'work' of demonstrating that she has done well between appointments. However, preference organisation suggests she should avoid self-praise whilst producing an agreeing second assessment on the topic, so her response is constrained in a variety of ways. The patient's talk meets these preferences for agreement and modesty whilst also reporting successful treatment behaviours in a way that emphasises her own effort and agency. This demonstrates considerable sophistication in the handling of multiple, possibly contradictory, interactional tasks and indicates the pervasiveness of devices employed by patients to connect reports of creditworthy actions to themselves. Once again, the patient can be seen to invoke normative issues when attributing medical success to her own activities. In line 10 she explicitly names a moral concern: "contro:l".

These four extracts show how patients implying successful weight loss progress tend to enhance their agency when reporting 'positive' treatment behaviours. They present implied successes as their own accomplishment and in doing so perform moral work. These responses are enabled by the doctor's opening questions (or compliments) and further turns which encourage talk to continue and do not overtly challenge patient talk. They are therefore a collaborative achievement. Patient responses implying lack of success are also produced through interaction but tend to unfold in very different ways. This is discussed next.

Implying lack of success

Extract 9 shows a typical response implying lack of success in weight loss progress. The patient reports weight gain followed by mitigating factors that reduce his responsibility for it. The patient also emphasises his agency in seeking to achieve medical progress.

Extract 9: Ian WMC 13th Dec (pp. 42-43 appendix B)

```
10. Doc:      So how uv things bin since (.) last time
11.           you came?
12. Pat:      U::m (.) I've put weight on, cos I've bin
13.           inactive
14.           (.)
15. Pat:       cos I've ad [me knee done.
16. Doc:                   [the knee
17.           (0.7)
```

```
18.  Doc:      Ri:ght.
19.  Pat:      But u:mm (0.2) ho:pefully: (0.7) I shoul-
20.            I might be getting a gastric band in
21.            February, (.)
22.  Doc:      Grea:t
23.  Pat:      that's what I'm working towards.
```

As seen in extract 3, the patient begins his opening question response with a slight delay, "U::m", followed by a report of weight gain. This is hearable in the context as implying lack of success in weight loss progress. The patient immediately connects the weight gain to being inactive (lines 12-3), indicating the absence of exercise, another suggestion of lack of success. This is then connected to having a knee operation (line 15). The repeated "cos" linking these statements constructs the connection between the weight gain, inactivity and the operation as causal and logical. The positioning of "I've ad me knee done." at the end of the turn constructs it as the ultimate cause of the other two factors. Its grammatical form carries a passive sense and conveys that the operation was something done to him rather than something he chose to do. By extension, this implies that being inactive and gaining weight also happened to him without his choosing. This turn conveys that he is knowledgeable about what influences his weight, and that he is not responsible for the gain.

After a doctor acknowledgement in line 18, the patient begins reporting some different news: that he may be having a gastric band operation (lines 19-21). The "ho:pefully:" at the start of the turn indicates that the patient regards the operation as something positive and further displays his knowledge of what is medically 'good' for him. The doctor

assesses this news in line 22 with "Great" and the patient continues in line 23: "that's what I'm <u>wor</u>king towards." This change back to a more overtly active grammatical structure and the use of "<u>wor</u>king" emphasise that this operation – in contrast to the knee one – is something the patient is actively choosing, pursuing and having an influence over.

Unlike the extracts in the previous section, the patient's opening question response can be seen to imply lack of success in weight loss progress. Furthermore, rather than emphasising his agency, the patient here minimises it. He connects his weight gain and inactivity to having an operation, a constraining factor which he did not choose. This has the effect of constructing the lack of success as something beyond his control, which he cannot be (morally) blamed for. The patient performs moral work by avoiding responsibility for what can be understood in this medical context as normatively 'wrong'. This pattern is seen again in extract 10 (an extension of extract 1)

Extract 10: Becky: WMC 25th Oct (pp. 10-12 appendix B)

```
26. Doc:     matter. How are you?
27.          (0.6)
28. Pat:     I'm alri:gh, I tri:ed the Xenical
29. Doc:     hmm?
30. Pat:     .hh But me docto::r thought differentley
31.          to yo:u,
32. Doc:     Okay.
33. Pat:     .hh An he seh and he did it (0.5) gradulee
34.          (1.0)
```

```
35.  Doc:     hmm.

36.  Pat:     Which at fi:rst there was no effect,

37.  Doc:     °kay°=

38.  Pat:     =but then when I it three: (0.7)

39.           I couldn't ave gone to werk.

40.           (.)

41.  Doc:     Oh really.

42.           (0.3)

43.  Doc:     Right.[So what did you do?

44.  Pat:          [Not un

45.           (0.8)

46.  Pat:     I wuz always on the loo:: wun't [ah?

47.  Mum:                                    [°yeah°

48.  Pat:     .>WEll I'd got me mum,< (.) that [when it

49.  Mum:                                      [Yeah

50.  Pat:     hit that [time, my mum ud ad a new knee:

51.  Mum:              [Yeah

52.           (0.3)

53.  Pat:     .hh so I was off werk so I was lucky,

54.           (0.3) but I've I I ad to come off them.

55.  Doc:     Ptch Did you go back down to two or did

56.           you just [stop them entirely?

57.  Pat:              [·hh No I'm jusuh I've?  not had

58.           any. Becus [.hh once I'd took the three,

59.  Doc:                [right

60.  Doc:     mm[hm?

61.  Pat:       [when I went do:wn, (0.3) I was still

62.           going a lo:t wasn't [ah? But they made

63.  Mum:                         [mmm.

64.           me really ungrey

65.  Doc:     mhm. Mm
```

```
66.  Pat:     I was starvin, so I've et a lot [mo:re=
67.  Mum:                                      [yu-
68.  Pat:     =.hh I've definitely put weight on
```

The patient begins her opening question response with reference to taking the weight loss drug Xenical. As in extract 5, reference to "the" drug suggests that Xenical has been discussed previously and that by taking it the patient has followed advice. The use of "tried" (line 28) indicates that she has made an effort with regard to a recommended treatment that encourages weight loss. However, its past tense formulation implies that, despite her personal effort, the dug taking was unsuccessful and has been stopped.

The patient then reports her experiences with Xenical. She reports that she followed GP advice to take it gradually and that when she reached the full dose of the drug she couldn't have gone to work (line 39), suggesting the drug had a very negative effect. The doctor then prompts further patient talk on the topic, first with a news marker (Hertiage, 1985), "Oh really.", in line 41 then a question in line 43: "So what did you do?" The patient responds that she needed the toilet all the time, using an extreme formulation (Pomerantz, 1986) "always on the loo::" which maximises the negative effects of the drug. Going to the toilet a lot is a common consequence of taking Xenical, which acts by stopping the body absorbing some fat from food. The fat leaves the body unabsorbed, resulting in anal leakage or 'involuntary diarrhoea'. The patient's talk here presents her as passive in these events by reporting what happened to her rather than what she did. It does not provide an explicit answer to the doctor's question. In lines 48-54 she states that she was off work anyway to look after her mother but that

she had to come off the drug. Here she reports what she did and so provides a more fitted answer to the doctor's question. However, this talk is still constructed to emphasise that the experience happened to her involuntarily, e.g., "when it hit that time" line 48 and 50. Her report of coming off the drug comes after this talk about its negative effects. This enhances her assertion that stopping was a necessity not a choice: "but I've I I <u>ad</u> to come <u>off</u> them." (line 54). What could be seen as a rejection of a valid weight loss intervention is instead presented as a logical outcome of her experiences and not something she can be blamed for doing.

In lines 55-56 the doctor asks a question about the Xenical. The question maintains the current topic but unlike previous continuers, such as "kay" (line 37), it projects a specific structure for the patient's response. The patient has already stated that she has "come off" the drug but the doctor asks whether she lowered the dose to two a day or stopped it entirely. It is possible that this question 'hints' at the correct reaction to Xenical, since lowering the dose would decrease the unpleasant effects whilst still providing some weight loss benefit. This hinting may connect to the apparent difficulty the patient has forming her response from line 57. Her initial "No I'm jusuh" is cut off and she restarts the turn stating that she has not had any of the drug. She then refers to going down (line 61) but says that she was still going to the toilet a lot, directing a confirmation soliciting tag question towards her mother. It is possible that this apparently contradictory response – switching from not taking any to going down – orients to the normative element implicit in the doctor's question. The doctor does not pursue an explicit response and instead acknowledges the patient's talk with tokens such as "Right" (line 59) and "mmhm" (line 60).

After her question to her mother, the patient continues with more talk about Xenical: "But they <u>ma</u>de me <u>re</u>ally <u>un</u>grey" (lines 62 and 64). This reports another problem with the drugs. Positioning them as the grammatical subject of the talk once again emphasises her passive role. This problem is reinforced by the upgrading of "<u>un</u>grey" to "<u>st</u>arvin" in line 66. The patient then says "so I've <u>et</u> a lot more" (line 66). The "so" connects her feelings of her hunger to her action of eating more, positioning it as the logical consequence of the way the drug made her feel. It also hints at weight gain. The patient then mentions weight directly: "I've definitely put <u>wei</u>ght on". This is presented as a strong assumption, leaving room for the scales to contradict it but simultaneously displaying that the patient is aware of her (lack of) progress.

The patient's long response implies lack of success by reporting a series of problems taking Xenical and expressing an assumption that she has gained weight. She hints at a lack of success early in her answer but does not make her assumed weight gain explicit until the end of her response. She delays this 'bad news' until after she has spoken about what happened to her and how the drug made her feel. This enables the patient to produce a very different kind of opening question response than by simply stating weight gain straight away. Her references to unwanted, constraining problems enable her to explain the implied lack of success in a way that suggests she is not personally responsible for it. Instead, she displays it as something that happened to her despite her efforts to follow medical advice and lose weight. Once again, the patient performs moral work by distancing herself from apparent 'incorrect' behaviours. As in the previous extract, the doctor does not 'blame' the patient for her lack of success and – despite one

hint at what might be a 'correct' mode of conduct – produces turns that enable her to deliver her defensive report.

The shrouding of news about weight gain before reporting it explicitly is a form of delay that has similarities with 'bad news' telling observed by Maynard (2003). The patient's answer can also be seen as an example of 'defensive detailing' (Drew, 1998 following Jefferson, 1985) in which a speaker builds up a case for something being reported (e.g., weight gain) as troublesome but includes various details to suggest he/she is not responsible for that trouble, thereby implicitly rejecting possible moral censure. Interestingly, the patient has selected to report this negative news ahead of news from her consultation in Cleedon which she has already mentioned (see extract 1) and which turns out to be far more positive. The selection of this particular news and associated defensive account may therefore perform some particular work relevant to this phase of the encounter. It is also noticeable that the patient produces a longer, more complex response than the patient in extract 9. In extract 9, the patient reports weight gain straightforwardly and almost immediately. Here the patient produces a long, narrative response that includes a series of mitigating factors. Attributing weight gain to a medically required operation could be seen as normatively less problematic than attributing it to a personal decision to stop taking a prescribed drug. It is possible to see corresponding nuances in the moral work performed in these two extracts.

These extracts show the typical features of patient responses that imply lack of success in my data. Patients report information hearably associated weight gain and weight gain behaviours (or general ill health, suggesting lack of overall medical progress - see extract 11).

They connect this information to external or unavoidable constraints, including health complications or pressures of family life and work (see appendix B). These constraints serve as mitigating factors which minimise the patients' personal agency in connection to what can be understood as normatively 'wrong' weight gain. This performs moral work by defending the patients' position as 'good'. Within these responses, patients also emphasise their willingness and efforts to become well. This also performs moral work.

Patient responses implying lack of success often take the form of relatively long reports, as seen above. However, where patients produce shorter answers, they can also be seen to minimise their agency in certain ways. The final two extracts provide examples of this. In extract 11, the patient's initial response is a very negative short assessment. It is followed by talk which hints at medical problems but positions responsibility for them away from the patient.

Extract 11: Gwen DOC 12th Dec (pp. 17-18 in appendix B)

```
7.   Doc:     HOw are you?
8.            (1.0)
9.   Pat:     Terrible.
                 ↓
```

```
10.  Doc:      O::h dear. Why's that

11.  Pat:      Oh I'll get my drug list out for a

                          ↓
```



```
12.               sta::rt.
```

Following the doctor's opening question in line 7, there is a 1.0 second silence before the patient produces a single word response: "Terrible." This is the same kind of downgraded assessment seen in extract 4. It both suggests and delays a report of some 'trouble' to follow (Jefferson, 1980). In line 10 the doctor produces a hearably sympathetic "O::h dear." followed by a question seeking expansion of her answer (thereby treating it as medically relevant). The patient responds: "Oh I'll get my drug list out for a sta::rt." and reaches for her bag. The reference to her drug list suggests a medical connection to her previous strongly negative assessment. It also hints at lack of success by implying that she requires a number of drugs for a number of problems. In this context, these problems are likely to be affected by her weight and to have an effect on her weight loss attempts. The sense of lack of success is enhanced by the "for a sta::rt." which implies she has further problems not yet mentioned. Whilst hinting at problems, the patient's turn also functions to separate her from this lack of success. Her talk places her problems with the drug list, something external to

her, rather than with her own body or medical progress. Instead of reporting the existence or onset of medical problems requiring drugs and therefore invoking her own body and/or health behaviours, her talk suggests that her problems lie in the piece of paper currently in her bag.

In the final extract, the patient's short response takes the form of a complaint.

Extract 12: Pam DOC 9th Jan (p. 20 appendix B)

```
1.   Doc:    ↑So how are you? ˙h

2.           (0.5)

3.   Pat:    I was alri::gh till I got on the sca:les

4.           he:re

5.           (1.1)

6.   Doc:    Right.
```

After a 0.5 second silence in line 2 the patient begins her opening question response in line 3. Her initial "alri::gh" fits the "how are you?" and appears neutral/positive. However, its formation in the past tense suggests a negative contradiction to follow. The patient completes her turn with, "till I got on the sca:les he:re". This is a reference to being weighed on arrival at the DOC. The 'I was [positive] x until' structure suggests a negative 'y' to follow and is hearable as a kind of complaint (Drew and Holt, 1988). It implies, but does not state directly, that the patient is not happy with the recorded weight and by extension, implies that this weight showed an unsuccessful gain. Her reference to the "sca:les he:re", with rising intonation placed on each word, indicates

that they are the source of her problem rather than her own actions, meaning that the bad news of weight gain is their, rather than her, responsibility.

In her talk, the patient hints at weight gain and minimises her own responsibility for it. This is done through a complaint which places the source of the trouble (her weight record) away from herself. This is one of several ways patients minimise their agency when implying lack of success in weight loss progress. Earlier I showed that patients implying successful progress between appointments tend to emphasise their agency when talking about their treatment behaviours. I have also shown that patients consistently orient to themselves as knowledgeable about their condition and as making an effort to become well. These various issues can be connected to moral concerns surrounding obesity and patienthood, as I argue in my discussion.

5.5: Discussion

This chapter analysed opening questions and responses; sequences that initiate the start of medical consultations. My analysis showed that opening questions in the fieldwork clinics often share their wording with general enquiries, with "how are you?" occurring in half the consultations. These turns are hearable as opening questions due to features of their delivery. Specifically, they are spoken after the completion of initial greetings and introductory sequences. As seen in extract 2, they tend not occur in positions where they could be heard as reciprocating a patient general enquiry. They also typically occur when the doctor and patient are in physical positions suggesting they are ready or nearly ready for the business of the encounter to begin.

The patient is usually sitting down when the question is asked and the doctor is sometimes sitting but sometimes standing close to his chair. The doctor produces the question with his gaze directed towards the patient. The questions may be prefaced with terms such as "so" and "but anyway" which underline their relevance to the consultation. The same features are observable in the few cases where opening questions take a different wording. They are also present in the two deviant cases of the possible compliment "you're looking well". It is possible that the occurrence of these features may be sufficient to enable a patient to orient to an opening question as oncoming even before it has been delivered (extract 7). The features are not necessarily all present in each case and the absence of one or more of them may be relevant to the small number of cases in which more than one possible opening question was produced.

Patients indicate that they are treating the turns as opening questions by delivering medically relevant talk. This takes the form of assessments and/or information reports about their health status and treatment behaviours between appointments. In producing these responses, patients imply success and lack of success in weight loss progress. 'Successful' patients report positive news about diet/exercise, medical improvements etc whilst 'unsuccessful' ones report factors associated with weight gain or ill health in general. In doing so, they construct their agency in different ways: enhancing agency in connection to treatment activities associated with 'success' but minimising it in relation to activities associated with lack of success. In addition, patients frequently display knowledge about their condition and efforts to become well. In this discussion I argue that, as well as

accomplishing the start of consultations, these sequences make visible moral concerns relating to obesity and patienthood.

I have shown that when producing opening question responses, patients' talk is hearable as implying success or lack of success in weight loss progress. The ways in which they do so have some similarities with the reporting of 'good' and 'bad' news and crucially, differ according to how patients construct their agency. 'Successful' patients enhance their agency to associate themselves with positive progress. 'Unsuccessful' patients minimise their agency by invoking external or unwanted constraints on their weight loss efforts, indicating that are not responsible for weight gain. In producing these answers, patients perform moral work. They invoke normative understandings of positive and negative weight loss behaviours, constructing diet, exercise, etc as creditworthy, whilst treating the absence of such behaviours as potentially blameworthy. These constructions correspond with certain moral concerns about obesity identified in the first two chapters of this thesis. As I have discussed, various medical, governmental, sociological and interest group claims-makers orient to obesity as in part a moral problem symbolising individual failure through laziness and greed. Within this 'moral model', the obese individual can regain moral standing by making an effort to become thin and displaying self-restraint. The patients in these data invoke similar themes in their talk. They display evidence of efforts to master their bodies, credit themselves for moving away from a devalued, obese body and avoid taking responsibility for lack of success. These issues invoked in the talk resemble apparent societal dynamics surrounding obesity and functions to claim any credit and reject any censure that those dynamics might imply.

The moral work performed in these opening questions and responses can also be seen to establish patients as 'good' patients in the medical setting. Patients use their talk to display knowledge about their condition and indicate that they are compliant and willing to make an effort to become well. Their talk can be seen to attend to the behaviours of the 'sick role' (Parsons, 1956 and 1975; see chapter 1). As described previously, individuals in the sick role benefit from the 'privileges' of being exempt from certain obligations and being treated as not responsible for their condition. However, they also have the 'responsibility' of attempting to exit the sick role by seeking and co-operating with expert help and being willing to get better. In this secondary care setting, patients have already sought expert help and their continued attendance at the clinics constructs them as 'legitimately' ill. In my data, patients do not use their opening question response to justify entrance into the sick role (see discussion of Heritage, in press, as above) rather they display attempts to exit it. Patients implying successful weight loss progress indicate efforts to exit the sick role via positive reports, plus their own willingness to become well and to co-operate with medical advice. Patients implying lack of success justify their continued position within the role by reporting constraining, mitigating factors that impede their efforts to leave it. Patients who have gained weight between appointments can be seen to be in a particularly difficult position since they could be regarded to have worsened their condition through (further) undesirable, voluntary behaviours of over-eating and under-exercising. In their responses, these 'unsuccessful' patients pre-empt any possible criticism that they have not been doing 'enough' to try to get better. They also often emphasise their continued willingness and determination to exit the role despite the existence of unavoidable constraints. In their

responses, patients therefore invoke normative requirements that resemble the sick role. By doing so, they attend to the moral implications of meeting, or failing to meet, the responsibilities of patienthood.

Another function performed by this moral work is to suggest a framework for the entire consultation. As noted at the start of the chapter, opening question responses enable patients to present their own agendas in their own terms. By implying successful weight loss progress, patients can establish not only the positive news they report in their initial response as their own accomplishment, but also any further evidence of progress that might follow later in the consultation, such as during the weighing examination. They create an interactional environment in which their treatment successes can be credited to them, thereby possibly creating a compliment-soliciting environment. 'Unsuccessful' patients use their talk to present the bad news they report and any more that will follow, as not attributable to themselves. This is a form of pre-emptive defence in which patients establish lack of fault in relation to potentially blameworthy news before any blame has been expressed. This may explain occasions where patients select to produce a bad news report even when more positive news is also available. For example, in extract 10 'Becky' selects to report her negative experiences with Xenical rather than her successful appointment at Cleedon, which has led to her being placed on the waiting list for bariatric surgery. Her narrative of the drug's unfortunate effects presents a better defence of her reported weight gain, which is ultimately confirmed on the scales. It suggests that if only she were prescribed a more suitable intervention, her efforts would ensure weight loss. Meanwhile, a report about Cleedon could be heard to

suggest that despite a successful consultation she has proved unable to lose weight. Patients therefore appear to use their opportunity to produce extended talk in these opening sequences to design answers that suit their (moral) agenda for the consultation.

The openings of consultations, and the moral work performed in them, are jointly accomplished by the doctor and patient through interaction. The non-specific wordings of the opening questions from the doctor are treated by patients as soliciting information relevant to the medical context. In their responses, patients refer to a variety of topics and orient to the consultation as one in a series of meetings, thereby constructing it as a routine encounter. The non-constraining wordings of the opening questions are fitted to the moral work performed by patients in their responses. With the exception of the deviant case in extract 8 (which noticeably topicalises positive rather than negative progress), they do not propose a specific topic for the patient to address or a specific way his/her answer should be designed. This means that whilst supplying a hearable opening question response, patients can also select what information to report and how to report it. Answers referring to weight, health or lifestyle can all be produced as relevant to the wording of the question and explicit reports of successful weight loss/gain etc can be produced immediately, delayed or only hinted at. Patients can display their willingness to become well in addition to reporting their actual behaviours. As such, they have the opportunity to report information and construct their agency in ways that support the normative position they are taking. This collaboration continues as the doctor takes turns which treat the patient's answer as relevant to the consultation and encourage it to continue. The doctor

does not explicitly accept or reject the patient's position and potential challenges are not made (extract 5) or are made implicitly (extract 10).

These findings make important points relevant to healthcare practice, sociology and CA. Existing studies (e.g., Garafanga and Britten, 2003) demonstrate to healthcare practitioners how opening questions shape the opportunities patients have to talk about their concerns. These findings add an awareness of the moral work prevalent in patient talk and the role opening questions can play in its occurrence. Another relevant issue is the policy requirement (chapter 1) that obese patients take some responsibility for condition and cure. By attending the clinics, patients acknowledge their condition as a medical problem. However, the analysis shows that whilst they take responsibility for successes, they avoid responsibility for lack of success. It is worth considering whether this avoidance may create tensions in the encounter, in particular in discussions over treatment interventions (see chapter 7).

My findings also demonstrate that talk in opening sequences of consultations invokes normative issues that have resonance with sociological concepts of the sick role and the moral model of obesity. Crucially, the analysis shows that these moral issues do not pre-exist a given medical encounter but are bound up in practices of talk. My analysis also contributes novel findings to areas of interest in CA. It provides examples of opening questions and responses in routine, secondary care consultations and suggests ways in which they may be connected to the specific setting. It also establishes that, in addition to accomplishing particular medical tasks, talk between doctor and patient frequently performs other (often moral) functions simultaneously.

These two CA-relevant themes continue to be important throughout this thesis, as shown in the next chapter on crediting turns in the consultation.

Chapter 6: Praising patients at every opportunity: Crediting turns in the fieldwork consultations

```
1.  Doc:    But you do loo:k,
2.          (0.6)
3.  Doc:    [a lot better
4.          ((door makes loud slamming noise))
5.  Pat:    °huuhuh°
6.  Doc:    °a lot better°
7.          (0.5
8.  Pat:    hhhh
9.          (0.3)
10. Doc:    °good.°
11. Pat:    I do fee:l? (1.0) I been fee:ling better
12.         (0.2)
13. Doc:    mmh:m.
14. Pat:    Like I suh-bit more energy, ye:h
```

6.1: Introduction

This chapter documents some analysis that seemed straightforward at the outset but which soon became complex and took on new directions of interest. The analysis was inspired by a data session in which the above extract was discussed. It was observed that the doctor's turn in lines 1-3 was 'quite like' a compliment but that the patient's response was a bit 'unlike' typical compliment receipts identified in CA. This interested me as the NICE Clinical Guidance on Obesity (2006: section 1.2.4.7; see chapter 1) advises practitioners to compliment patients,

stating: "To encourage the patient through the difficult process of changing established behaviour, healthcare professionals should praise successes – however small – at every opportunity." I decided to analyse compliment sequences in my data as a form of praise. I was particularly interested in how the self-praise avoidance typical in compliment receipts might be visible in the fieldwork clinics where, as already shown, patients routinely emphasise their agency in connection to creditworthy treatment behaviours. I hoped my findings would provide commentary on compliment sequences in institutional settings and the NICE guidance on praise. However when I came to collect cases I experienced a very pressing problem: I could not identify which turns were compliments. Whilst a number of turns, like lines 1-3 above, looked 'quite like' compliments, they did not completely resemble those discussed in canonical CA studies and I was unable to find a CA-informed definition of what a compliment is.

In this chapter I describe the methodological difficulties I experienced identifying 'compliments' and outline how I eventually selected cases for analysis. Analysis focuses on doctor turns explicitly crediting the patient for something 'good' and reveals that these turns take a variety of forms. Patient responses also take various forms and do seem to minimise self-praise. They can also be seen to assert patients' authority to know about and comment on their own progress, whilst orienting to other institutional actions initiated by the prior turn. I discuss the implications of this complex interactional landscape for the NICE guidance and argue these crediting sequences reflect certain features of the clinic setting. I also argue that there is scope for CA to focus more on the form of first turns such as compliments.

6.2: Praise, compliments and conversation analysis

Conversational praise can be analysed as compliment turns and compliment receipts. Compliment turns have been studied from a variety of linguistic perspectives, including pragmatics and speech act theory (see Golato, 2005). These studies argue that compliments tend to follow a limited, formulaic structure. Knapp et al (1984) state that most compliments comment on a recipient's appearance, performance or personality traits. Manes and Wolfson (1981) add that they tend to take the grammatical forms "I like/love your….", "That's a ……" or "Your X is …" and use a narrow range of positive adjectives such as "good", "beautiful", "pretty" and "nice".

CA studies have tended to concentrate on compliment receipts - although in his lectures Sacks (1992, see e.g., lectures 15.1 and 29) talks about the difficulties of constructing a 'safe' compliment which does not insult the recipient or anyone else who may hear it. The seminal work was conducted by Pomerantz (1978; 1984a) in her analyses of assessments and compliment receipts. Pomerantz observes that an assessment invites the recipient to agree or disagree, with agreement the preferred response. Agreements are often accompanied by second assessments, which frequently upgrade the terms describing the assessable. For example, "good" may be strengthened to "very good" or "great". Assessments can function to secure a recipient's participation in talk (Pomerantz, 1984a) and agreeing second assessments can display alignment between interactants (Heritage, 1985). However, assessment sequences can also invoke complex issues regarding access and rights to knowledge (Heritage and Raymond, 2005). Pomerantz states that by making an assessment a speaker

treats the object of talk as assessable and "claims knowledge of what he or she is assessing" (Pomerantz, 1984a: p. 57). With a second assessment the speaker claims shared access to the assessable and may mark this second assessment to display greater (or lesser) knowledge than the first speaker. The issue of who speaks first and who displays greater knowledge may become relevant in the interaction (Heritage and Raymond, 2005). In this way, assessment sequences are places where issues of epistemic authority may be played out.

Pomerantz (1978) describes compliments as special forms of assessment which place additional preference constraints on the recipient. Following Goffman (1971), she treats compliments as 'supportive interchanges', which prefer an acceptance. This combines with the preference for agreement following an assessment. However, agreeing with and accepting a compliment can be heard as self-praise, a violation which may be sanctioned by others (Pomerantz, 1978). Compliments invoke cross-cutting preferences: agreements risk sanction for immodesty whilst disagreements risk the breakdown of alignment in talk. Pomerantz's analysis of compliment responses in American-English shows that most recipients orient to this tension by producing responses that fall between agreement and disagreement and display modesty rather than self-praise. Agreements tend to be weak, typically scaling down the praise terms in the compliment. They may combine with other actions, such as acceptance. Pomerantz gives the following example:

```
A:    Oh it was just beautiful
B:    Well thank you Uh I thought it was quite nice
```

(Pomerantz, 1987:p. 94)

Here B agrees with A (as with all Pomerantz's examples, there is no explicit agreement token) but downgrades the quality of the referent "it" from "beautiful" to "quite nice". Downgraded agreements often follow turns in which the referent of the compliment is not the recipient, e.g., "that", "it" etc is the grammatical subject rather than "you". Since the compliment does not directly praise the recipient, an agreement is less likely to be heard as self-praise. Disagreements also scale down the credit and are marked with disagreement tokens such as "but", "though" etc.

```
A:     Good shot
B:     Not very solid though
```
(p. 99)

Referent shifts return the compliment to the first speaker or move the praise from the recipient to another person or object:

```
A:     You're a good rower, Honey.
B:     These are very easy to row. Very light.
```
(p. 102)

Straightforward disagreements and appreciations such as "thank you" are also found following compliments but less frequently than these other forms.

The turns in Pomerantz's corpus share some of the grammatical structures – "that is", "you are" – and adjectives "good", "nice" – identified in other analyses as formulaic compliments. Pomerantz did not explain how she recognised particular turns as compliments,

treating them as 'self-evident'. This is a familiar theme across CA studies. A number of these studies discuss how far issues of face, self-praise avoidance and 'safe' compliments are relevant across cultural settings (e.g., Golato, 2002, Golato, 2005; Huth 2005 and Yu, 2003). Analysts have also added other compliment responses to Pomerantz's typology: the recipient produces no verbal or non-vocal response by not talking at all or continuing on the previous topic (Golato, 2005; Knapp et al, 1984 in non-CA work), or the recipient produces a turn that provides further information about the compliment referent without evaluating or accepting it (Herbert and Straight, 1989).

Some studies have considered compliment responses in institutional settings. Shaw (2006) studied telephone calls to a home birth telephone helpline. She observed that compliments given by the call operators to callers (typically expectant mothers planning a home birth) function as a kind of 'emotion work' constructing the caller as capable and competent. Shaw found that compliments in her data took the formulaic structures "you're …", "that's …" etc, but used a wider use of positive adjectives, including "terrific", "courageous" and "clever". They tended to occur in the pre-closing phase and implied that since callers were capable, they did not need more help and the call could end. Shaw found that acceptances and appreciations were particularly frequent in her data and suggests this reflects the institutional aim of the helpline. The helpline aimed to empower callers by constructing them as positive and this could lessen the sanction against self-praise.

Gathman, Maynard and Schaeffer (2008) analysed talk during telephone-based cognitive assessment surveys, in which participants underwent a series of research tests. Call operators were instructed to

provide positive feedback in the form of compliments after individual tests and the authors analysed how recipients responded to the talk in this space. They found recipients very frequently produced no response after these compliments, and if they did respond, their utterances were minimal. Gathman, Maynard and Schaeffer argue that in addition to dealing with the constraint against self-praise, recipients' non/minimal responses indicated that they did not have enough knowledge of the situation (cognitive testing) to produce a second assessment, downgraded or otherwise. The call operators rarely pursued a response to the compliment and instead the silence was often used as a means to close the sequence of talk and move on to a new one.

These studies suggest that the form of compliment sequences may be connected to (institutional) setting. Compliment turns may function to perform institutional tasks and responses may be contingent on the level of recipients' knowledge or the aims of the encounter. These issues are relevant to my own study. In the previous chapter I showed that when answering opening questions patients demonstrate knowledge about their own condition and their ability to assess it. They also emphasise their agency in connection to treatment successes, thereby possibly creating a compliment soliciting environment (Maynard, 2003). How might knowledge displays and self-crediting be relevant to compliment receipts? In chapter 5 I also described a possible compliment that was responded to with information relevant to an opening question response. This raises the possibility that compliments might perform a variety of clinic tasks.

6.3: Analysing praise in the fieldwork clinics

When I set out to collect cases in my data I immediately encountered problems establishing which turns were in fact compliments. Unlike Gathman, Maynard and Schaeffer I could not identify them through an interactional space in which they were institutionally designed to occur and unlike Pomerantz, Shaw and others I found it difficult to treat cases as self-evident. Turns that may appear 'obvious' compliments in other settings seemed ambiguous in the clinics. For example, "you look well" is a comment on someone's appearance that in ordinary talk looks like a compliment through an implied reference to general well-being. However, in the fieldwork clinics the same turn could be heard as a visually-based assessment of the patient's apparent health. Instead of, or as well as, being a compliment it might be the practitioner fulfilling his/her institutional task of assessing progress. Similarly, "that's fantastic" could compliment the recipient or could comment on the patient's progress without crediting the patient directly. For example, it could refer to a drug the patient has been taking and which has led to rapid weight loss.

In CA terms these ambiguities could be seen as unimportant. Since talk is achieved indexically, a turn takes its function and 'meaning' through the way it is treated in subsequent talk. In that case, compliments can be identified through compliment responses. This is a key epistemological strength that enables CA to produce empirical descriptions of interaction. However, selecting only those turns which recipients treat as compliments risks overlooking atypical responses and cases where a turn is hearably delivered as a compliment but not treated as such. Furthermore, many actions identified as compliment

responses can also perform other actions. For example, "thank you" marks acceptance of a range of supportive actions and a no talk response can signal, amongst others, lack of hearing, lack of understanding, disagreement or 'resistance' (see chapter 7). Therefore a second turn cannot necessarily demonstrate whether a first turn is being treated as a compliment – particularly if the first turn doesn't 'look like' a compliment anyway. With these limitations in mind, I suggest that it could be beneficial for CA to pay more analytic attention to compliments and other first turns. After all, in her seminal analysis Pomerantz needed to identify compliments through the first turn alone in order to produce a typology of responses. Additionally, our recognition of 'obvious' compliments comes from some (common)sense of what these initiating turns look like. Whilst the response to a first turn remains the key for analysing the ongoing interaction, it is still possible to study the first turn itself, beginning perhaps, with those common-sense understandings. This may represent a future direction for conversation analysis (Heritage, J. personal communication, June 2008). In the previous chapter, I described how CA analysts have been able to identify the features of an initiating opening question through consideration of wording, intonation, timing of delivery etc. It may be possible for CA to do the same with compliments. In the meantime, unable to find a CA-informed definition of what a compliment is and unable to identify any 'obvious' cases, it took me a number of attempts to find a footing with my data.

I quickly abandoned my first collection of 'compliments' and began to collect examples of positive assessments, hoping they would provide a proxy for complimenting first turns. However, I faced similar difficulties identifying first turn assessments (e.g., is "you've lost a lot of weight"

an assessment or statement of fact?) and distinguishing between talk that was designed to be positive (e.g., "you look very well") and talk that was hearable as positive only in context (e.g., "you look thinner"). I was also concerned that I was not engaging with the key element of praise. In the course of my reading I came across this definition of compliments from a non-CA source: "A speech act which explicitly or implicitly attributes credit to someone other than the speaker, usually the person addressed, for some 'good' which is positively valued by the speaker and the hearer" (Holmes, 1988: p. 446). CA has many points of disagreement with speech act theory, offering valid criticisms of its use of non-naturally occurring data and its inattention to sequence (Schegloff, 1988). Despite this, I found the definition useful as it describes interactional phenomena that can be identified empirically. Therefore I used it as a guide to collect cases in my data.

I collected a very large number of cases then chose a subset to analyse. I selected to analyse cases where the doctor explicitly credits the patient. I chose these as I was confident about empirically identifying cases in which some "good" was hearable as being explicitly referred to (for example, "well done" can typically be heard as a form of credit without knowledge of the context in which it is delivered). In addition, explicit, direct credit suggests a strong form of praise, most likely to resemble 'obvious' compliments. I would therefore be able to make stronger analytic claims about the relevance or otherwise of self-praise avoidance in these sequences. Finally, by crediting directly, these turns orient to patients as active agents. Since agency had already emerged as a key issue in my analysis I was keen to pursue it further.

In the findings section below I outline how I included turns in the collection and the major findings of my analysis. I describe both how the crediting turns are formed and how they are responded to. Given the difficulties outlined above, I do not label them as compliments. However, my analysis shows that issues of knowledge and self-praise avoidance are relevant in these sequences.

6.4: Findings

I collected 35 cases in which the when the doctor explicitly credited the patient for some 'good'. This excludes credits produced during letter dictations in the WMC (see chapter 4 and example in appendix C p. 75) since the credit was spoken about the patient but not to him/her in way that enabled a response. The credits in this collection are all part of doctor turns that are followed by a space in which the patient can respond. Reformulations, repeats and increments were all counted as one case if spoken as part of a multi-turn unit. The full transcripts are in appendix C. Some transcripts include relevant prior talk but others begin with the crediting turn, with prior talk summarised rather than transcribed. Where line numbers in chapter transcripts begin after 1, this indicates that the appendix transcript includes some prior talk.

I begin my findings by discussing the form of the doctor's crediting turns. I then describe the different ways patients respond to the turns, focusing on responses which refer to the doctor's credit in some way. Analysis shows that the doctor's turns tend to take particular forms and share some similarities with formulaic compliments. They frequently perform other actions and may be marked to indicate the doctor's limited access to the topic he is crediting. In response, patients do

seem to avoid self-praise, but in ways that are consistent with any self-crediting talk they may have already produced. They also mark their knowledge about their own condition and their ability to assess it. Furthermore, patients generally align with any additional function performed by the doctor's turn, so that certain institutional tasks are achieved collaboratively.

6.4.1: Formation of turns

Turns are constructed to explicitly credit the patient using a variety of grammatical and lexical devices. They vary in length, ranging from short phrases to complete grammatical units, often occurring as part of a longer turn. Where the turn was a short phrase, this was almost always "well done" although "sensible thing" was also observed. These phrases comment on an immediately prior action or patient report, as shown in extracts 1-3.

Well done/sensible thing

Extracts 1 and 2 are examples of the crediting turn "well done".

Extract 1: Pam DOC 9th Jan (p. 71 in appendix C)
Three minutes into the consultation, the patient is providing an extended update of her treatment actions/progress between appointments.

```
1.   Doc:     Do you fee:l that you've lost weight?
2.   Pat:     YE::s
3.            (0.2)
```

```
4.  Doc:      hmm.

5.            (0.6)

6.  Pat:      Yes.

7.            (.)

8.  Pat:      Well I pu-ONe thi:ng I'm trousers

9.  Doc:      mm:m.

10.           (.)

11. Pat:      Don't usually wea:r trousers, and it is a

12.           si:ze down,

13.           (0.2)

14. Doc:      well done
```

Example 2: Julie WMC 13th June (p. 66 appendix C)

The patient is standing on the scales for her weighing examination.

↑

```
1. Doc:              We:ll do:ne. Excellent
```

In extracts 1 and 2 "Well done" functions as a stock congratulatory phrase. It does not have a grammatical subject but the verb participle "done" conveys an implicit "done by you" to the recipient. The adverb "well" attaches a positive reference to the "done" and therefore to the

recipient's actions. Consequently, when addressed to the patient, "well done" can be heard to directly praise the patient's actions.

In extract 1, the doctor asks if she feels that she has lost weight and she replies "Ye::s" (line 2). She then accounts for this answer in lines 8, 11 and 12. Following the patient's positive report that she is wearing trousers and they are a size down, the doctor says "well done" (line 14). This is hearable as commenting on the patient's previous turn and crediting her for fitting into smaller clothes. As a short phrase, it quickly passes the conversational floor back to the recipient without marking any change of topic. It can therefore be heard as a kind of continuer (Jones, 1997).

At the start of extract 2, the doctor's gaze is directed towards the results display on the scales. Line 1 follows a silence in which the patient's weight appears on the display. The "We:ll done. Excellent" can be heard as a positive reference to the displayed weight, with the "We:ll done" crediting the patient for it. As the first talk after the completion of weighing, this is also hearable as announcing the end of the examination and signalling that the patient can return to her chair.

Extract 3 shows a less common short phrase producing explicit credit.

Extract 3: David WMC 8th Nov (pp. 58-59 in appendix C)
This extract occurs towards the end of the consultation. The patient has complained of constipation and queried whether it may have been caused by a drug he is taking. The doctor has just recommended that the patient take a laxative.

```
21.  Pat:      [We:ll I ] took some lactilose az well,

22.           so:

23.  Doc:      Sensible thing
```

In response to the doctor's advice to take a laxative, the patient responds that he has done so, naming a particular brand. In line 22 the doctors says "Sensible thing" which hearably comments on the patient's prior turn. Once again, the turn does not have a grammatical subject but here implies a "that was/is a" structure with "that" referring to the act of taking the laxative. The word "sensible" conveys a meaning of being prudent and wise. These are positive characteristics generally attributable to people or people's actions rather than things. Here the doctor can be heard to credit the patient explicitly for making a prudent and wise decision to take the laxative.

Complete grammatical turns/turn units also take a variety of forms. Turns using the structures "you look"/"you are looking" follow a visual assessment of the patient and comment positively on his/her 'healthy' appearance. This is shown in extracts 4-6.

You look/you are looking/you do look

Both extracts 4 and 5 occur at the start of the consultation.

Example 4: Atif DOC 12th Dec (p. 73 in appendix C)

```
1.   Doc:          Hello::. You're looking we:ll

                      ↓
```


Example 5: Miriam 8th Nov (p. 57 in appendix C)

```
1.   Pat:        (Are you alri:ght?)

2.   Doc:        Welcome

3.   Pat:        .hh Pleased to see yuh

4.   Doc:        You too ((smile voice)) you too.

5.               (0.4)

6.   Doc:        You're looking very we:ll:
```

                                        ↓

Extract 6 occurs towards the close of the consultation (see chapter 8), whilst the doctor is preparing forms for the patient.

Extract 6: Pam DOC 9th Jan (pp. 63-64 in appendix C)

↑
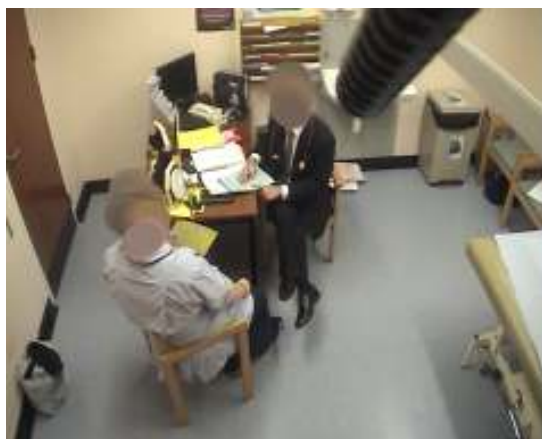
```
1.   Doc:      But you do look,

2.             (0.6)

3.   Doc:      a lot better
```

In each extract the patient is made the grammatical subject of the crediting turn through the pronoun "you". This positions the patient as the agent of the talk and the recipient of the credit it conveys. The verb form "look" explicitly relates to the patient's appearance and is connected to the adjective "well" or comparative adjective "better". These are positive terms so the turns are hearable as crediting the patient for having a good appearance. In the context of the fieldwork clinics both "well" and "better" can be heard to mark a specific bio-medical reference. As shown by the video-stills, these turns tend to be delivered whilst the doctor is looking directly at the patient, and often has been doing so for some moments before he speaks. This 'expert

gaze' enhances the hearing of the turns as medically relevant and suggests that they vocalise the doctor's visual assessment of the patient. Where this occurs at the start of the consultation, the turn may be treated in response as an opening question (see chapter 5).

You are doing/You have done

Turns with "you are doing" and "you have done" credit patients' actions. These turns often comment on patients' overall performance rather than some prior action/report.

Extract 7: Timothy WMC 14th March (p. 61 in appendix C)

This extract takes place after a long discussion of the patient's successful exercise regime.

```
1.  Doc:        ↑Okay, so: I don't think I' ve got
2.              anything else to change un I: cos I
3.              think you are doing so well,
```

In lines 1-3 the doctor tells the patient he doesn't think he has anything to change as the patient has been doing "so well". This last part of the turn credits the patient directly by making him the grammatical subject ("you") and describing his activities ("doing") in positive terms ("so well"). The doctor's "↑Okay" in line 1 acknowledges the series of information reports from the patient and suggests that he may be treating them as now complete. The sound-stretched "so:" then suggests that the doctor is delivering the upshot of this extended talk and connects not making any changes to this information. The credit

that follows can therefore be heard to relate to the patient's overall progress and to connect to the reference to making no changes. A practitioner telling a patient there are no treatment changes to make could be heard as negative. It could imply that the patient is beyond medical hope or that the practitioner is not making a suitable effort. The reference to the patient doing well removes these possible hearings by making clear that no change is a positive development, directly linked to the patient's own success. Here the doctor's crediting turn also functions to account for his (non) treatment proposal. It is noticeable that credit is prefaced with "I think", marking it as his own opinion.

Extract 8: Jim WMC 8th Nov (pp. 72-73 in appendix C)

The patient has been talking for some time about his successful weight loss efforts.

```
1.  Pat:    We have a mea:l.
2.          (.)
3.  Pat:    The wife's retired now
4.          same as meself, so we have one meal
5.          (1.1)
6.          around about twelve o'clock
7.          (0.7)
8.  Pat:    tt if we have anything else about
9.          four o'clock it'll
10.         be a bowl of soup or (.) some fru:it or
11.         something.
12.         (1.2)
13. Doc:    tt [All I can say is
14. Pat:       [so
```

```
15.            (1.3)
16. Pat:    I-It's=
17. Doc:    =the: the: proof of the pudding [as you
18. Pat:                                      [yeah
19. Doc:    say=
20. Pat:    =yeah=
21. Doc:    =is that you you've done [so well
```

In lines 1-11 the patient talks about his eating habits and in lines 13-18 the doctor produces an assessment that culminates in telling the patient he has done "so well". As in extract 7, this directly credits the patient by making him the grammatical subject and describing his actions positively through the adverb "well". In addition to crediting the patient, this turn can be heard as a summary assessment which initiates a move to close the current topic of talk. (Button, 1987, 1990; see chapter 8). It comes after a series of assessable reports from the patient but does not refer to any specific details about them. "All I can say" (line 13) carries a sense of 'wrapping up', indicating that the doctor is making a general, summary comment on what he has heard. The doctor then employs a figurative expression, "the: the: proof of the pudding as you say", a common feature in closing talk (Drew and Holt, 1998). Finally, the positive comment about doing well can be heard to suggest that since the patient has made good progress in this area (dieting) the topic does not need to be discussed any longer.

The majority of grammatically complete crediting turns use the verbs "look" and "do" to credit patients' appearance and activities. However, in extract 9 "can" is used to credit the patient's capabilities.

You can

Extract 9: Miriam WMC 28th May (p. 55 in appendix C)

The patient has been talking about her successful weight loss through dieting.

```
1.   Pat:     But with foo:d, (0.5) an I'm in
2.            contro:l .hh an as soon as you
3.            break that contro:l then you kind
4.            of get on the: (0.5) rollercoaster
5.            (0.8)
6.   Doc:     [Ptch
7.   Pat:     [Buh
8.            (0.4)
9.   Doc:     But actually wuh-one of the things
10.           which strikes me is thut .hh when
11.           you:'ve when you've actually fallen
12.           o:ff (.) you cun actually get straight
13.           back on agai:n.
```

In this extract, the crediting turn also functions as a disagreement. In lines 1-4 the patient connects being 'in control' with food. She begins by referring to herself, "I'm in contro:l" (lines 1-2), then switches to "you" plus present simple, "you break that contro:l…", suggesting she is now talking generically rather than specifically about herself. As she is here talking about negative treatment behaviours, this minimises her agency in the same pattern as seen in chapter 5. The patient talks about getting on a rollercoaster, suggesting a series of unwelcome ups and downs when control is lost.

After a pause of 0.8 seconds the doctor and patient produce a lip-smack and "Buh" in overlap. After another pause the doctor begins a turn in line 9 which concludes with direct credit. His turn begins with two disagreement markers "But <u>act</u>ually", followed by a kind of opinion marker: "wuh-one of the things which <u>str</u>ikes me". The doctor talks about falling off and getting on again and so appears to take up the patient's image of the rollercoaster. His use of the present perfect combined with the "actually" in, "when you've actually <u>fal</u>len off", indicates that he is referring to the patient's past experiences rather than to people in general. The "you cun actually get <u>str</u>aight back <u>on</u> agai<u>:</u>n." is therefore hearable as referring to the patient individually. It suggests that the patient has the ability to get back on the rollercoaster. Although this does not actually follow the logic of the patient's original metaphor, it is hearable as crediting her with the ability to regain control over food when she has broken it. Placing the patient as the grammatical subject of the talk combines with the modal "can" to directly credit her abilities. The "cun …get" formulation is relevant to past, present and possible future actions so its use emphasises that the doctor is referring to the patient's general abilities. The "actually" in line 12 adds a sense that this is a positive achievement, even if it goes against what the patient expects of herself. It also emphasises the turn's construction as a disagreement with the patient's original statement.

This overview indicates that crediting turns in these data do share some similarities with the compliments discussed above. They reference patients' appearance, performance and, more rarely, capabilities. The grammatical constructions used are limited, frequently involving "you look" and "you do". The vocabulary employed is also

limited, particularly in the frequent use of "well" (but see the different constructions in extracts 15 and 16). The turns function to credit the patient for something immediately prior or to credit the patient in a more general way. They frequently perform additional functions. As these extracts show, "you look" can perform an opening question, and "well done" can act as a continuer or announce the end of an action. Crediting turns can also summarise a topic and move it to a close or produce a disagreement.

By producing these crediting turns the doctor indicates that he has knowledge relating to the patient and asserts the right to express it in first position. Longer turns are often prefaced with opinion markers, as shown in extracts 7 and 9. In terms of making a compliment these markers can be seen to weaken the strength of the credit conveyed by marking it as subjective opinion rather than objective fact (Wiggins and Potter, 2003). More generally, they also indicate that the doctor is treating himself as accountable for his medical talk (Peräkylä, 1998). It is interesting to consider what in particular the doctor is accounting for in these turns. In extract 7 the doctor's credit functions to account for his recommendation of no treatment change. The "I think" prefacing the credit might emphasise that account. In extract 9 the doctor's "one of the things which strikes me" can be heard to modify his disagreement by indicating that he is not directly contradicting her. Therefore opinion markers may connect to the additional functions the crediting turns perform.

Opinion markers may also connect to the type of access the doctor has to assess what he is crediting. In extract 7 the doctor is responding to the patient's report of continued exercise and in extract 9 to the

patient's talk about dieting. In each case his credit is based on what he has heard from the patient. It may be aided by knowledge of the patient's weight history but the doctor has no form of direct 'evidence'. Opinion markers may therefore display the doctor's relative lack of access to details that form the basis of these crediting turns. Marking credit as opinion leaves room for it to be upgraded if subsequent evidence (such as weighing) reveals the patient's assessment to be correct or downgraded if the patient's report is later seen as inaccurate. In either case the doctor's institutional identity as 'expert' is relatively unthreatened. In the same way, telling the patient that he/she "looks" well allows for the possibility that the patient may not actually be well and that this may be revealed (or have been implied[6]) at some other point. Another relevant point is that opinion markers acknowledge that someone else – for example, the patient – may have superior access to the information the credit is based on and may produce a different perspective on it. In the next section I show that patient responses do sometimes mark their knowledge of their condition. They also orient to institutional tasks and avoid self-praise to certain extents.

6.4.2 Responses

A variety of responses were found. As with the crediting turns, responses often seemed ambiguous with regard to the actions they performed, frequently appearing to perform more than one simultaneously. Consequently, it proved difficult to categorise them

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[6] In extract 6, the talk occurs in the close of the consultation and the patient has already complained her recorded weight loss was not as good as she expected (see chapter 5, extract 12). Here the "But you do look, a lot better" marks a contrast between the ways her health can be assessed: visually and through a weight record.

adequately. Table 6.1 characterises the responses according to how they refer to the credit in the prior turn. This does not capture their full character and variation but is a useful means to initiate a more thorough description.

Response to crediting turn	Number of cases
Agreement	17
Other references to credit in previous turn	8
No direct reference to credit	7
Acceptance/appreciation	3
Total	**35**

Table 6.1: Frequency of patient response types according to how they refer to the credit in the doctor's prior turn.

These categories are rather complex and best described through data examples. They all follow talk in which patients were the object of direct credit. If they were compliments, following Pomerantz's typology, we might expect a low incidence of agreement and for those that occur to include downgrades. However, agreements are the most common response type. As I show below, responses do often 'dilute' the credit in some way, but there are no straightforward downgrades. Furthermore, in contrast to Shaw's analysis, acceptances/appreciations are rare. I begin this section with two examples of less frequent responses: acceptances and no reference to the credit. I then focus on the more frequent responses which refer directly to the credit by agreeing with it or performing some other action. Throughout the analysis I also show

how patients mark their responses to display awareness of their own condition and align with ongoing institutional tasks.

Acceptance

There are three acceptances/appreciations in the data. In extract 10, below, the patient's "thank you" can be heard to accept the credit whilst orienting to the close of the consultation.

Extract 10: Ian WMC 11th July (pp. 74-75 in appendix C)

↑

```
7.    Pat:    Ha how much d'you say? Twenty four
8.            kilograms?
9.    Doc:    Er: you were a hundred and forty now
10.           you're a hundred and sixteen
11.           (1.1)
```

↑

```
12.  Doc:      Well done Mr Graham.

13.             (.)
```

↓


```
14.   Pat:      Thank you very much

15.   Doc:      Buh bye then.
```

At the start of the extract the doctor and patient are both standing and have moved towards the door, indicating readiness to leave the room and end the encounter. The patient has lost a lot of weight following gastric band surgery and the doctor has agreed to his proposal that he be discharged from the clinic. Earlier the doctor calculated the patient's total weight loss since his operation. In lines 7-8 the patient solicits a

repeat of that information. The doctor turns back towards his notes then reports the patient's change in weight in lines 9-10. After a pause of 1.1 seconds he then credits the patient with "<u>We</u>ll <u>do</u>ne Mr Graham". This may refer to the prior talk about weight loss amounts, but the extended silence suggests it may refer to the patient's overall progress. During this turn, the patient opens the door and begins to walk through the doorway. He continues this during his "<u>Th</u>ank you very <u>mu</u>ch" in line 14. This turn appears to accept the doctor's credit and can also be seen as a kind of appreciation token that patients typically produce at the end of consultations (see chapter 8).

No direct reference to credit

In 7 cases the patient did not make any direct reference to the credit. This occurred in three different ways: no talk (3 cases); continuation of a prior turn (2 cases) and the initiation of a new sequence of talk (2 cases. In extract 11 below, the patient treats produces no talk in response to the doctor's crediting turn.

Extract 11: Ian WMC 11th July (p. 69 in appendix C)
This extract occurs at the start of the consultation.


```
    1.   Doc:      How are you then?
```

```
2.   Pat:      I'm very well, thank you.
```

↓


```
3.   Doc:      mm::hmm.

4.             (0.3)

5.   Doc:      You look it.
```


↑

```
6.             (0.4)

7.   Doc:      Hang on. Sorry. Have a seat
```

The doctor delivers his talk in line 1 whilst standing by the door and making a gesture that encourages the patient to enter the room. In line 2 the patient responds with an assessment: "I'm very well, thank you."

The doctor then says "mm::hmm." with a rising then falling intonation that suggests a positive, even admiring stance. After another pause the doctor says "You look it." The "it" is hearable as referring to the "very well" in the patient's turn, so this is a kind of reformulation that directly credits the patient for having a positive appearance. Noticeably, it changes the wording through which the credit is assessed, from "being very well" to "looking very well", perhaps marking the doctor's currently limited access or indicating that any treatment progress has made a visible effect. During the pause in line 6 the patient starts to move towards a chair. The doctor is standing in his way and his turn in line 7 is spoken as he moves aside. The patient does not produce any response to the doctor's crediting turn. His action of moving to a chair is consistent with the opening of the consultation and the doctor does not pursue a response from the patient.

The patient produces no talk in response to the doctor's crediting turn. He begins a non-vocal action that is consistent with the phase of the encounter but that that does not appear responsive to the talk. There are two other cases of no talk responses in the data (see appendix C pp. 67-69). In one the patient directs talk on a different topic to another person in the room and in the other the patient makes no response to a credit that occurred in the first part of a multi-part turn.

Producing no talk was one way in which patients did not reference the crediting turn. As noted above, the other ways observed were the continuation of prior talk and the initiation of a new sequence of talk. These various responses treat the prior credit as unheard. Earlier in the chapter I noted that making no reference to prior talk has been identified as a form of self-praise avoidance. However, the lack of direct

response means it is unclear whether recipients actually orient to the turns as crediting them. Therefore it is unclear whether their responses are designed to avoid self-praise or perform some other action. In extract 11, the patient's non-response could treat the doctor's crediting talk as a sequence-closing third turn (Schegloff, 2007) not requiring a response and enabling him to pursue physical movement that will further the start of the consultation. The production of continued talk could indicate a hearing of the crediting turn as a continuer and talk on a new topic could treat the prior crediting turn as closing the current one. It is also possible that these responses are designed to perform the two functions - avoiding self-praise and responding to other actions - simultaneously.

References to the crediting turn:

In most cases patients responded with turns that directly referenced the credit in some way. Agreements were one way this was done. Of the 17 cases of agreement found in the data, 7 were standalone turns and in the other 10 agreement was followed by some other action.

Standalone agreement

In seven cases patient's entire turn was composed of "yes" or some other agreement marker such as "right", "okay" or "mmhm". The strength of agreement varied according to turn delivery and where the doctor's prior credit was delivered in a multi-part turn, it was often ambiguous which talk the patient was referencing (Jones, 1997; see examples in appendix C pp. 53-63). Agreements often occur in sequences where patients orient to their own actions as positive, as shown in extracts 12 and 13.

Extract 12: Miriam WMC 28th May (p. 55 in appendix C)

At the patient's request, the doctor has been looking in his notes to tell her how much weight she has lost over the course of her clinic visits. The doctor has been unable to find all the relevant figures.

```
1.   Doc:       But basically you've been coming [do:wn

2.   Pat:                                        [Yea:h

3.              ri:ght

4.              (.)

5.   Doc:       [So:: I think you've bin doing very we:ll

6.   Pat:       [That's good

7.   Pat:       Ye:s
```

In line 1 the doctor produces a positive summary of the patient's overall weight loss. The patient agrees/acknowledges this information in lines 2-3 then assesses it positively with "that's good" in overlap with the doctor. The doctor completes his turn out of overlap and credits the patient for doing "very we:ll". In line 7 the patient says "Ye:s". This is hearable as referring to the doctor's prior turn and as agreeing with it.

The patient produces an assessment of her weight loss progress before the doctor credits it her for it. Although "that's good" does not credit herself explicitly, it does comment on her own progress as positive. In extract 13 the patient also talks positively about her progress before agreeing with the doctor's credit.

Extract 13: Pam DOC 9th Jan (p. 54 in appendix C)

The patient has reported that she is continuing to go to the gym.

```
1.  Pat:    I'm not scared to go in places like that
2.          any mo:re
3.          (0.6)
4.  Pat:    That's[tha'ts another tick for me bo:x,
5.  Doc:         [(°      °)
6.  Pat:    you kno:w
7.  Doc:    We:ll done
8.          (0.5)
9.  Pat:    Yeh
10. Doc:    .hhh U::n whuh-which gym is it you go to?
```

In lines 1-2 the patient says "I'm not scared to go in places like that
any mo:re". This is hearable as referring to the gym and other places
to exercise. Her turn suggests that whilst she was once scared to go to
such places, she has overcome this and now goes to them without fear.
This implies two creditworthy successes: overcoming a fear and making
medical progress through exercise. After a 0.6 second silence the
patient says, "That's tha'ts another tick for me bo:x" (line 4). The
image of ticking a box suggests the successful completion of a
(necessary) task, so the patient can be heard to imply credit for doing
well. The "another" implies that this is the latest in a series of
successes. In line 6 she completes her turn with a tag question, "you
kno:w". In line 7 the doctor credits the patient with "well done". After a
0.5 second pause the patient says, "Yeh", which functions to agree with
the doctor's turn. The doctor then asks a question about which gym the
patient goes to.

In both extracts the patient responds to the doctor with a short
agreement. The crediting turns follow talk in which the patients credit

themselves for positive treatment actions. As in chapter 5, this self-crediting talk can be seen to create a compliment soliciting environment in which the patient makes relevant some kind of positive response from the doctor. The patient's talk in extract 13 can particularly be seen in this way. After producing her first positive talk about going to the gym, she explicitly emphasises her success in line 4. The tag question in line 6 then actively solicits a response relevant to this success.

This prior self-crediting talk may be relevant to the type of answers the patients provide. In the context where the patient has already credited him/herself, the production of a modest, self-praise avoiding response to the doctor's crediting turn could be seen as inconsistent. It could undermine the strength of the success the patient has previously reported or be undermined by that report, suggesting that the patient is now being insincere. By contrast, a standalone agreement from the patient is consistent with his/her prior talk. It can be heard as self-praise, but as there is no further talk (such as an upgrade) it does so minimally. As the rest of the analysis shows, the presence of patient talk emphasising success is common in response types that refer directly to the crediting turn. Also relevant are two other features shown in extract 13. Firstly, there are signs of possible difficulty forming the response - here shown in the significant silence between the crediting turn and patient's answer. Secondly, the doctor's subsequent talk does not treat the patient's response as inappropriate.

Agreement followed by another action

In 10 cases patients agreed with the crediting turn and then produced
some further talk. In one case this further talk repaired something the
patient had begun to say previously. In four cases further talk was an
appreciation/acceptance – with "thank you" twice being used to accept
the credit and/or orient to the close of the consultation, as in extract
11. In three cases patients agreed then assessed the credit. In doing
so, they reformulated the assessment rather than explicitly upgrading
or downgrading it. Extract 14 is an example of this, occurring at the
start of the consultation.

Extract 14: Miriam WMC 8th Nov (p. 57 in appendix C)


```
1.  Pat:     (Are you alri:ght?)

2.  Doc:     Welcome ((holding out hand to patient))

3.  Pat:     .hh Pleased to see yuh ((shaking hands))

4.  Doc:     You too ((smile voice)) you too.

5.           (0.4)

6.  Doc:     You're looking very we:ll:

7.  Pat:     Ye:s, I think I've done alright since I

8.           last saw you,
```


This extract was also seen in chapter 5, on opening questions. The
doctor's turn in lines 7-8 credits the patient for "looking very we:ll:".
The patient responds with an agreement, "Ye:s" followed by "I think
I've done alright since I last saw you,". This provides information
relevant to her medical condition and so gives a kind of opening
question response. It is constructed as an assessment and is modified

as personal opinion through "I think". Where the doctor referenced the patient looking well, the patient responds in terms of how she has done. This reformulates the terms in which the assessment is made. Therefore her use of "done al<u>ri</u>ght" is not a direct downgrade of the doctor's "very w<u>e</u>:ll". However it does dilute the strength of the credit to some extent, so can be heard as a kind of modesty display.

In the two other cases the patient agreed and produced information relevant to the topic of the credit without overtly assessing it as either positive or negative. Extract 15 is one example.

Extract 15: Timothy WMC 14th March (p. 62 in appendix C)

The doctor and patient have been discussing the patient's successful gym visits.

```
1.   Doc:    You kno:w the actual bulk of muscle
2.           there as well as bulk there=
3.   Pat:    mm[h:m.
4.   Doc       [You know you .hh the muscles uh buh-
5.           beginning to show through the:[re.
6.   Pat:                                  [Yeah
7.           I can definite and ah cun actually LIft my
8.           own WEight now, .hh lifting myself u:p
9.           over a (.) a chin on thing. [so
10.  Doc:                                [°°Can't do
11.  Doc:    tha:hht°° huh [(              °°excellent°°)
12.  Pat:                  [ehuh huh
13.  Doc:    s'quite impressive actually.
14.  Pat:    **Yea:h [I I'm working at it, it was hard to**
15.  Doc:            [(       )
```

```
16. Pat:     begin with, but you know you keep pushing

17.          at it, yuh know your body adapts to it

18.          so:=

19. Doc:     =Yeh
```

In lines 2-3 the doctor comments that the patient's muscles are beginning to show, whilst touching one of the patient's biceps. In lines 6-9 the patient appears to agree that he can see the muscles and then reports being able to lift his own body weight now. His "actually" in "cun actually LIft" carries a sense that this is an unexpected achievement and so by extension is something difficult that he has successfully achieved. This sense is enhanced by the word stress on "LIft" and "WEight" whilst the "now" emphasises that this represents change and, by extension, an improvement.

The doctor begins a reply in overlap in line 10, saying: "°°Can't do tha:hht°°". This has an implicit "I" as the grammatical subject and is produced with laughter particles. The turn is hearable as a jokey comparison of what the patient and doctor can do. The patient overlaps with laughter in line 12 as the doctor produces some unclear talk. Out of overlap the doctor says: "(°°excellent°°) s'quite impressive actually" (lines 11 and 13). As a continued response to the patient's turn, this talk is hearable as referring to the patient's reported strength. The "actually" ties it to the patient's turn and its final position suggests the doctor is now being serious in contrast to his previous jokey response (Clift, 2001). The "excellent" positively assesses the patient's reported improvement and the "impressive" conveys a sense of admiration for the achievement. In combination with the implied comparison between

the doctor and patient's abilities, this talk is hearable as crediting the patient directly.

The patient responds with "yeah" in line 14. He adds "I I'm wor̲king at it," before saying it was hard to begin with. He switches to a generic 'you' and says you keep pushing at it and your body adapts. This talk takes up the topic of body strength credited in the doctor's turn. The patient does not explicitly upgrade or downgrade the credit and his talk is constructed as providing further, neutral information on the current topic. However, he does dilute the quality of the credit in some ways. Although he previously reported being able to lift his own body weight now, his reference to working at it implies the skill is not yet complete. The reference to it being "har̲d" and the switch to a generic 'you' also dilute the credit to some extent. Therefore the patient can be seen to minimise self-praise in response to the crediting turn – plus perhaps the doctor's own modesty display in lines 10-11. However, he also emphasises his own efforts in connection to the credited action, for example through "har̲d", "keep pushing at it" etc.

Extract 16 is the second example of a response that produces further information without overt assessment. The patient seems to have difficulty forming a response before referring back to information mentioned earlier in the consultation.

Extract 16: Jim WMC 8th Nov (pp. 57-58 in appendix C)
The patient has been telling the doctor how he alters his diet according to the daily reading on his scales.

```
9.  Doc:      I thu I thi:nk (0.4) y'know

10.            listening to yer own body like

11.            you're obviously doing, is

12.            act[ually the ke:y here.

13. Pat:          [Ye:h

14. Pat:      Yeah yeah. °I mean° it's it's er and

15.            then thuh uz say uhm (1.0)

16.            my pedal machine I just broke [it

17. Doc:                                     [Oh yea:h

18. Pat:      had to go an buy a ne:w one=

19. Doc:      =Whe:re do you buy those from?
```

In lines 9-12 the doctor produces a crediting turn. The "key here" sets up the action being commented on ("listening to yer own body") as positive, whilst the "like you're obviously doing" connects it to the patient himself. Once again, the turn is marked as an opinion: "I thi:nk" (line 9). The patient responds with a repeated agreement in line 14, "Yeah yeah", then continues "°I mean° it's it's er and then thuh uz say uhm". The "I mean" suggests the patient is about to clarify or provide more talk on an established topic, most likely the current topic of 'listening to his body'. The repeated "it's it's" also suggests a forthcoming comment on the topic, perhaps a second assessment or some further information. The patient then appears to experience difficulty completing this talk; after "er" he mark a possible topic shift with "and then". The following "uz say" seems to refer back to something the patient previously mentioned, then after "uhm" and a 1.0 second silence he refers to his exercise pedal machine (line 16) – something he talked about earlier in the consultation.

It is unclear what type of action is being projected by the patient in the talk immediately following his agreement, but this example highlights the difficulties patients sometimes display responding to the doctor's crediting turn. The recurrence of delays and repairs could suggest a difficulty recognising the action performed by the doctor's turn and/or the appropriate response to it.

These extracts show that patients agree with the doctor's crediting turn by producing a standalone agreement or an agreement plus further talk. The further talk performs a range of actions but typical agreement upgrades and compliment downgrades are absent. The absence of upgrades and the presence of some dilution of the credit suggest that patients avoid self-praise to some extent. However these crediting turns often occur in environments where patients have already presented themselves as successful, so a straightforward downgrade could appear inconsistent or insincere. In contrast to Pomerantz's typology, agreements in these data always incorporate an agreement token. To varying extents, these tokens assert patients' knowledge about their own condition, demonstrating they are able to evaluate the doctor's observations. Further talk relevant to the topic and reformulations of the credit enhance these displays of knowledge.

When making agreements patients concur (to some extent) with the crediting turn produced by the doctor. There are a number of other ways in which they refer to this credit without directly agreeing (or disagreeing) with it. These turns take a number of forms, two of which are described below.

Other references to the credit

In eight cases patients referred to the doctor's credit without agreeing or disagreeing with it. These actions are rather complex and an overview is best given in table form. See table 6.2, below.

Action referencing the credit (without agreeing or disagreeing with it)	Number of cases
Reformulation	3
Relevant talk with no assessment made	2
Reference to different prior knowledge/assessment	2
Question	1
Total	**8**

Table 6.2: Table showing the different ways patients referenced the crediting turn without agreeing or disagreeing with it

In two cases the patient produced further, neutral talk on the topic of the credit in a similar way to extract 15. Iin one case the patient asked a question about the credit (see appendix C pp. 64, 65 and 67). In three cases patients produced an assessment that reformulated the terms of the original credit. Two examples are shown below.

Reformulations

Extract 17: Julie WMC 13th June (p. 64 in appendix C)
At the start of the consultation, the patient has just sat down.

```
1.   Doc:    Y' looking we:ll
2.   Pat:    E::r feeling very well
3.   Doc:    Good.
```

Extract 18: Pam DOC 9th Jan (pp. 63-64 in appendix C)

```
1.   Doc:    But you do loo:k,
2.           (0.6)
3.   Doc:    [a lot better
4.           ((door makes loud slamming noise))
5.   Pat:    °huuhuh°
6.   Doc:    °a lot better°
7.           (0.5
8.   Pat:    hhhh
9.           (0.3)
10.  Doc:    °good. °
11.  Pat:    I do fee:l? (1.0) I been fee:ling better
12.          (0.2)
13.  Doc:    mmh:m.
14.  Pat:    Like I suh-bit more energy, ye:h
15.          (1.5)
16.  Pat:    More get up un go: °huuhuh° heheheh .hhhh
17.  Doc:    I'd like you to:, >hand this in to
18.          reception,<I'd like to to see [you again
19.          in four months
```

In extract 17 the doctor tells the patient she is "looking we:ll" and in extract 18 that she looks "a lot better". Both patients respond by reformulating "look" to "feel". In extract 17 the patient delays her answer with "E::r" then says she is "feeling very well". In extract 18

the patient laughs and the doctor partially repeats the credit, which could be heard to pursue a response. In line 11 after an abandoned start, the patient says that she's been "fee:ling bet̲ter" and then accounts for this assessment.

As with extract 14, the patients produce assessments relevant to the original credit but reformulate the way in which the assessment is made. These reformulations do not reject the credit offered by the doctor and unlike referent shifts in compliment receipts they do not shift the praise onto an external object. Since the doctor produces an assessment first, reformulating the credit may be a way to implicitly agree with it without appearing to overtly self-praise. Furthermore, reformulations may also reveal a difference between what the doctor and patients treat themselves as able to assess. In extracts 17 and 18 the patients reformulate "looking well" to "feeling well" and extract 14 the patient changes "looking" to "done" with an accompanying opinion marker. Just as the doctor does not treat a patient's actual health state as assessable at certain points in the consultation, it is possible that patients do not treat their health appearance as assessable. Instead, they assess their subjective health status – in terms of how they feel or how they think they have done. Once again, there is some evidence that the patients experience difficulty in producing these answers. In extract 17 the patient delays before responding and in extract 18 the patient's immediate response is laughter, which could be heard as marking a delicate interactional situation (Haakana, 2001).

Responses indicating different prior knowledge/assessment

In the two other cases, the patients produced responses indicating some prior knowledge/assessment relevant to the credit. Both occurred during weighing and displayed that the patient's prior knowledge/assessment was in some way different to the current weighing results. These responses may be heard to challenge the crediting turn as unexpected, but do not disagree with it.

Extract 19: Julie WMC 13th June (p. 66 in appendix C)

```
1.   Doc:     We:ll done. Excellent.
2.            (0.7)
3.   Doc:     [Thah
4.   Pat:     [That's lighter than mi:ne.
```

Extract 20: David WMC 13th June (p. 66 in appendix C)

```
1.   Pat:     Woo::h ye:s
2.   Doc:     Hundred and ninety nine, under
3.            two hundre:d, fantastic
4.            (2.5)
5.   Doc:     Well done
6.   Pat:     .hhh
7.            (1.5)
8.   Pat:     To he honest I thought it ud of gone up
```

In extract 19 the doctor credits the patient for her weight loss in line 1. Following a pause, both the doctor and patient start to speak in overlap. The doctor drops out and patient completes her turn in line 4:

"That's <u>ligh</u>ter than mi:ne". This can be heard as a reference to her own scales. The patient's talk refers to the weighing result as unexpected, but does not explicitly reject it. It also implies that the patient had weighed herself previously and had some expectation of what her weight was going to be.

Similarly, in extract 20 the doctor credits the patient for his weight in line 5 and after an in-breath and a pause the patient reports that he "thought it ud of gone <u>up</u>'. Again this expresses that the recorded weight was unexpected, without explicitly assessing it or rejecting the credit. It implies that the patient had formed his own assessment of what his weight was likely to be and conveys a 'diluting' sense as it suggests that the patient did not think he had done as well as this. By indicating that the amount of weight loss was unanticipated, patients can be seen to perform a kind of modesty display. Additionally, they make clear that they had formed their own assessments prior to the weighing and as such have knowledge about their own condition. In both cases there is a pause before the patient's response. During the pauses the patients are engaged with the physical business of moving off the scales. However this movement does not necessarily preclude verbal activity, so these pauses may again suggest some difficulty producing a response.

In these final examples, patients refer to the credit in ways that enable them to display their pre-existing knowledge and their ability to make assessments. They neither agree with the credit nor explicitly reject it and do not perform straightforward downgrades. As seen across these data, they sometimes dilute the quality of the credit indicating that they may be treating the doctor's turn as preferring self-praise. These

features, combined with the frequency with which crediting sequences incorporate issues of access to knowledge and relevant institutional tasks, creates a complex interactional landscape. The implications of this complexity are discussed below.

6.5: Discussion

This chapter was initiated by a single data extract which prompted an interest in how practitioners praise patients through compliments. Early analysis of my data was marked by methodological difficulties collecting suitable cases and a reluctance to identify compliment first turns through compliment receipts. I ultimately adopted a non-CA definition and collected examples of the doctor crediting the patient for some 'good'. These turns function to credit patients' health appearance, weight examination results, success reports and overall progress. They often occur in environments where patients have already referred to the topic of the credit in positive terms and can also be seen to perform a variety of other actions such as summarising a topic/phase, delivering an opening question, disagreeing or accounting for some other talk. The crediting turns take a variety of grammatical and lexical forms but often employ "you look…" and "you do…" structures in addition to "well" as a positive adverb and adjective suggesting good health. During longer turns, these credits are frequently delivered with opinion markers such as "I think".

Patients produce a variety of responses, with a small number of acceptances and some cases of no reference to the credit. In most cases the patient's answer references the credit in some way.

Agreements reference it through agreement tokens plus, sometimes, some further talk. This further talk neither upgrades nor downgrades the credit. In other cases, the further talk functions to align with other actions initiated by the doctor. Patients also sometimes refer to the credit by reformulating it, delivering relevant 'neutral' information or treating it as unexpected. These various forms sometimes dilute the credit to some extent and patients often displayed some signs of difficulty producing talk – for example through delays before answering, repairs and laughter. In this discussion I draw out the implications of these findings for the understanding of institutional talk and the NICE guidance on praise. First I discuss the relevance of my methodological difficulties to conversation analytic study.

The methodological difficulties I experienced in this analysis centre on recognising first turns. When reading existing CA studies, I found that most analysts treated compliment turns as self-evident and did not describe what features enabled their identification. I found I could not do this with my data as turns rarely appeared 'obvious' compliments. A typical CA solution to this problem would have been to select cases in which patients treated prior turns as compliments by producing recognisable compliment receipts. However, this approach risked missing atypical cases and also risked misunderstanding how the recipient treated the turn, since some compliment receipts share their form with other actions. More fundamentally, whilst responses are the key to analysing how talk unfolds, surely other analysts' treatment of compliments, assessments etc as self-evident indicates that these turns have recurrent features which mark out the actions they perform, irrespective of how they are responded to? If we accept this, it becomes clear that there is room for CA to focus more on the form of

first turns. Identifying the features that make a turn hearable as a compliment would enable a deeper understanding of talk and help to distinguish such turns even when they do not appear straightforward or 'obvious', for example when they are delivered in medical settings.

In response to my methodological problems, I adopted an external definition of compliments in order to proceed with analysis. Although I recognise the limitations of approaches such as speech act theory, I maintain that they may provide insights that CA currently lacks. For example, non-CA studies have frequently noted that compliments follow formulaic grammatical and lexical structures. It is worth considering that these formulaic structures may provide a means through which recipients are able to identify first turns as compliments and that their absence may result in difficulties recognising them, as experienced by this analyst, and in difficulties responding to them, as seen in these data. As a final argument in favour of greater analytic focus on first turns, I refer to another non-CA source. In Felicity's Condition, Goffman (1983a: p. 50; see chapter 3 in this thesis) writes: "…an account of second utterances in terms of their contingency on a first leaves unexplained how there could be any firsts; after all, from where could they draw their design? Conversation could never begin."

The crediting sequences in these data frequently connect to the setting of the fieldwork clinics in the forms they take and the additional actions they perform. An immediate observation about the crediting turns is that they topicalise issues directly associated with the medical business of the clinics: looking well, doing well on the scales and achieving progress with diet, exercise etc. A second point is that they mark the limited access the doctor has to the topic of the credit. For example, at

the start of the consultation, the doctor has no knowledge of the patient's progress other than how he/she looks, so turns such as "you look well", are consistent with this level of access. In addition, the doctor rarely has direct access to the patient's treatment behaviours since they occur away from the setting. Therefore, opinion markers such as "I think", mark this limited access and enable the doctor to produce an (expert) evaluation whilst leaving room for later adjustment. In doing so however, they can also be seen to lessen the quality of the praise by treating is as subjective.

Patient responses can also be seen to connect to context. In my analysis I focused on responses that referenced the credit and observed that they often occurred in environments where patients had already reported, and emphasised, their own actions as positive. In this environment, a disagreement or downgrade in response to the credit might suggest that the patient is now being insincere or that his/her earlier positive talk was exaggerated. Instead, patients reference the credit without rejecting or it and therefore produce turns consistent with their prior talk. Patients do not upgrade the credit and sometimes dilute its quality, through vocabulary changes, reformulations and by treating it as unanticipated. This suggests that they orient to the doctor's turns as requiring some form of self-praise avoidance. By producing agreement tokens, further relevant information and talk that treats credit as based on information that differed from their own prior assessment, patients display that they have pre-existing knowledge of their condition and assert their right to express it. These knowledge displays were also seen in the previous chapter on opening questions. The emphasis on agency in relation to successes, noted above, plus the emphasis on personal effort evident in extracts 14 and 15, were also

observed in that chapter. I argued that these features indicate that when answering opening questions patients perform moral work to establish themselves as 'good' patients. The recurrence of the same features in these data, suggests that this moral work is central to the actions patients perform in the clinics.

Throughout the analysis I have noted that crediting turns often perform additional actions. These actions often relate to particular tasks of the clinic. For example, "you look well", in keeping with its frequent production at the start of the consultation may be treated as an opening question (extract 14). "Well done" can function as a continuer after a news report (extract 1) or announce the end of the weighing examination (extract 2). Credits produced in longer turns can function to summarise a current topic (extract 8), suggesting that talk can move on to a new task, disagree with a patient's view of his/her status (extract 9) or account for an expert recommendation (extract 7). This is not to suggest that these turns are always designed to perform an additional action or that when they do they are in any way less sincere that turns which 'just' credit the patient. But it does show that, as with many other types of talk, crediting turns can perform additional actions relevant to context and that this needs to be recognised in analysis. Although patients sometimes displayed difficulty forming responses to the turns, they always oriented to the additional actions performed by them. This was done as part of the response, for example in talk following an agreement token (extract 14), or through the entire response, such as "thank you" which can sometimes be heard both to accept credit and align with a move towards closing, (extract 10). Through these sequences the doctor and patient collaboratively

accomplish institutional talk and maintain the progress of the encounter.

Finally in this discussion, I reflect on the implications of my findings for the NICE guidance on praise. The guidance, quoted at the start of the chapter, takes the form of a single sentence advocating that practitioners praise patients at every opportunity. However, my data show that crediting sequences are very complex. The guidance could draw practitioners' attention to the various ways patients can be credited and point to how different types of credit may suit different phases/functions of the encounter. They could also point out that, since patients' sometimes display difficulty forming a response to the crediting turn, praising patients "at every opportunity" could have the effect of slowing down the progress of the consultation. Another complex issue is identifying when an "opportunity" to "praise successes" actually arises. This is because most successes are reported to practitioners and not observed by them. Patient reports of successful diet, exercise, etc behaviours can present an opportunity for praise but it is possible that direct evidence - for example, the patient's weight - may later contradict that report. Practitioners can accommodate this tension by marking the praise as subjective, but this can have the effect of weakening it. Guidance could also recognise that patients are likely to use their responses to the praise to demonstrate their knowledge of their own condition and orient to any other actions suggested by the practitioner's talk. This is not to suggest that praising patients is not a worthwhile activity or that patients do not benefit from it. However, it does show that praising is an interactionally complex action and that guidelines on how it should be done would benefit from

being based on empirical findings rather than abstract ideas. As ever, interaction is more complex than a single sentence can convey.

Chapter 7: "Where do you think we should go from here?" Soliciting patients' opinion at the start of the treatment/advice-giving phase.

7.1: Introduction

All medical consultations include some form of treatment phase. In addition to actual treatment provision, this phase may include verbal activities of treatment recommendations and advice-giving from the practitioner concerning what the patient should do to attempt to get 'better'. These activities are a key institutional task of the encounter but are interactionally delicate and often associated with 'resistance' from the patient. In this chapter, I discuss two examples of the start of the treatment/advice-giving phase in the fieldwork consultations. Each phase is initiated by a question from the doctor that solicits the patient's views on how treatment should proceed. I analyse how the patients answer the questions with treatment proposals and the extent to which the doctor aligns with these proposals before introducing his own opinion. The two interactions develop in very different ways and demonstrate that whilst soliciting the patient's opinion on treatment at the start of the phase can provide opportunities for alignment, it can also diminish opportunities to reach agreement about treatment. These findings have relevance to CA, sociology and healthcare delivery.

7.2: Advice-giving and treatment recommendations in healthcare encounters

The treatment/advice-giving phase in the fieldwork consultations involves the recommendation of new interventions and discussion of existing ones. This requires interactional activities connected to treatment proposals/presentations, decision-making and advice-giving. Such activities have been the focus of much sociological interest. Many studies have found that practitioners play a key role in shaping the talk that occurs before patients express a decision about treatment and may therefore shape how they reach these decisions. Some UK observational studies of the 1970s and 1980s (see chapters 3 and 4) attribute practitioners' asymmetrical role in these sequences to 'professional dominance' enabled by the structural power of medicine. By contrast, CA studies have shown that this may be a consequence of interactional features local to the encounter. For example Robinson (2001a), demonstrates that talk throughout the medical encounter can be characterised in terms of the practitioner initiating sequences and patients responding to them. Asymmetries of interaction, in which the practitioner is able to initiate the shape of talk about treatment decisions, are therefore consistent with normative sequence organisation. This has also been shown in specific studies of medical decision-making.

Collins, Drew, Watt and Entwistle (2005) characterise practitioner approaches to discussions of decision-making about treatment as existing on a continuum between 'unilateral' and 'bilateral' interactions. Whereas unilateral interactions treat decisions as already made,

independent of patient contributions, bilateral ones actively pursue patient involvement. This occurs for example, through accommodation of patient perspectives, invoking 'choice' and signposting that options are about to be presented. In a study of midwife-expectant mother interactions, Pilnick (2008) observed that the organisation of talk can result in medical options being presented in a non-neutral way. Pilnick found that midwives presenting the option of having a test for Down's syndrome appeared to invoke models of informed decision-making but simultaneously oriented to an assent rather than consent model of agreement. They also made appeals to expert medical authority and technology, conflated the tests with more routine ones and reported their potential benefits in non-neutral ways. Pilnick notes that some of these interactional features have been observed in other medical settings (e.g., Anspach, 1993) and that they may influence patient decision-making.

Other CA studies have shown that patients can and do use interactional devices to affect the outcome of decision-making discussions. Robinson (2003) notes that participants in medical consultations orient to a treatment proposal from the practitioner as requiring an agreement/rejection from the patient. In her studies of parent-practitioner interactions in US paediatric consultations, Stivers (2002; 2005; 2006) adds that this joint orientation to a patient response incorporates a preference for agreement, and that practitioners work to pursue agreement if it is not immediately produced. Stivers observed different ways in which parents withheld agreement. She refers to practices of non-alignment, such as silence, as 'passive resistance'. As argued in the previous chapter, a no talk response can convey a variety of actions including lack of hearing or lack of understanding. However,

Stivers argues that silences in her data often functioned as resistance since they were frequently treated by practitioners as indicating incipient disagreement and were also often upgraded to 'active resistance'. Parents actively resisted by producing talk that questioned the suitability of the proposed treatment or raised the possibility of alternatives. In response, practitioners frequently made concessions to the parent's expressed viewpoint – for example by prescribing 'unnecessary' antibiotics. Similarly, where parents directly or (more often) indirectly expressed a preference for a particular treatment, this was treated as a matter for negotiation rather than straightforward agreement or disagreement. Although rare, instances in which patients put forward their own direct treatment proposal had particular consequences for the interaction. They performed initiating actions which made relevant a response from the doctor and often led to practitioner concessions. Active resistance may therefore provide a device through which patients can pressure practitioners to alter their treatment proposals.

Advice-giving is also a topic of CA interest. Studies show that it is delicate activity across settings. In a study of mundane talk, Jefferson and Lee (1981) state that when a teller reports a 'trouble' this is not necessarily the same as reporting a 'problem' requiring a solution. A troubles-teller tends to solicit emotional reciprocity from the recipient rather than seek advice. Where advice is given in this environment, it is often rejected as tellers are reluctant to relinquish their interactional rights as troubles-tellers. Advice is most likely to be well received when something has been explicitly 'worked up' as a problem in the preceding talk, so that advice-giving emerges as a logical outcome of a problem presentation. Jefferson and Lee argue that the presentation of

a patient's medical concern is one example of an environment where something can be worked up as a problem (via a practitioner's diagnosis) making advice-giving relevant and therefore less likely to be rejected. Nevertheless studies have shown that advice is sometimes rejected in health-related interactions.

In a study of UK Health Visitor interactions with first-time mothers, Heritage and Sefi (1992) found that advice was only received unproblematically when it was delivered to a prepared recipient. This occurred when a mother directly requested advice or when a step-by-step sequence established the existence of a problem. Where this did not occur, mothers sometimes resisted the advice actively, asserting that they already knew the information or were already doing whatever the Health Visitor had recommended. More often, mothers produced unmarked acknowledgements, such as "mmhm", "yeh" and "that's right". These did not overtly accept the advice as informative and did not convey that it would be followed. Once again, these responses could be seen to convey a variety of actions in addition to resistance, such as lack of understanding following complex Health Visitor advice (Montgomery-Robinson, 1986). However, Heritage and Sefi describe them as practices of resistance and observe that they can lead to tensions in the subsequent talk. They argue that these tensions often occur because advice-giving is bound up with issues of face. Requests for advice can be seen as admissions of uncertainty, ignorance or incompetence, whilst the volunteering of unsolicited advice may be treated as presuming the recipient lacks knowledge or competence.

Similar tensions can be observed in other health-related encounters on 'sensitive' topics. Silverman (1997) analysed interactions during HIV

counselling sessions and found similar responses to advice-giving. Once again there was little overt resistance to counsellor advice but uptake was often minimal. Where clients did reject advice they did so in ways that adhered to the interactional preference for agreement, by mitigating and delaying disagreement.

This literature suggests a variety of themes relevant to my study. As with HIV, obesity is a 'sensitive' medical issue that can be seen as stigmatised in wider society. Additionally, like interactions in Health Visitor encounters, discussions of obesity can involve talk about the appropriateness of certain lifestyle behaviours. My analysis so far has shown that patients routinely present themselves as knowledgeable about their condition and enhance their agency in relation to behaviours that can be heard to imply 'success' in weight loss progress. By contrast, they minimise their agency and distance themselves from responsibility for lack of successful treatment progress. How might this affect decision-making about treatment? Is it possible that advice-giving or treatment recommendations from the doctor may be treated as challenging these displays of knowledge and agency, threatening the patient's normative position? If so, could this have consequences for the discussion, for example possibly leading to patient resistance?

7.3: Treatment discussions and advice-giving in the fieldwork clinics

The treatment/advice-giving phases in my data vary considerably in terms of length, actions performed and levels of patient involvement. The range of activities occurring may include: suggestions for

treatment change (or lack of change), questions and discussions about the advantages and disadvantages of certain interventions; opinion solicitation and opinion giving. The phase typically ends with agreement over how treatment will proceed and the consultation moves on to closing (see chapter 8). Most often this agreement was reached relatively unproblematically. For example, the patient agreed with a certain intervention recommended by the doctor, or the patient requested a treatment change and the doctor agreed to it. However in a few cases, non-alignment between doctor and patient did occur, resulting in often lengthy discussions before (modified) agreement was reached.

When watching the video data I noted a number of different ways in which the phase was initiated. In some cases it appeared to emerge through talk in the prior examination phase. For example, a comment on how the patient has begun to lose weight after beginning to take an anti-obesity drug might lead to discussion of the continued use of that drug. In other cases, it began with specific reference to one type of treatment intervention – such as that it should be continued, altered or stopped. In 9 of the 39 cases the phase was initiated by a question from the doctor soliciting the patient's opinion of how treatment should proceed. This was typically followed by the doctor giving his own opinion and further discussions about treatment.

This particular means of initiating the phase interested me and I wanted to analyse how the device of soliciting the patient's opinion first shaped the subsequent treatment discussion. I was also interested in why this device was used in some consultations and not others. Furthermore, this set of 9 cases included a rare example of

disagreement between the doctor and patient. Whilst in 8 of the 9 cases these phases progressed smoothly, one appeared to be a deviant case. On first observing it, I characterised the discussion as 'tense' and full of disagreement. The doctor seemed to be 'challenging' the patient's experessed treatment preference and asking questions that extended beyond purely medical matters. The patient appeared to be 'resisting' any suggestion that he might not be able to carry out his treatment proposal. It appeared unlikely that any form of agreement would be reached. I wanted to use CA to unpick my initial characterisations of the interactions in this deviant case and compare it to other, typical cases. I was particularly interested in comparing the different trajectories of the 8 'smooth' interactions and the single 'tense' one.

7.4: Findings

The analysis presented in this chapter is based on observation of all relevant cases and the close analysis of three particular cases, two of which are discussed here. Both extracts are very long, so for reasons of space and ease of reference, the reader is directed to follow them in appendix D and only short extracts are presented in the chapter. I use line and page references to connect my analysis to the corresponding place in the appendix transcript. The full transcripts include the continuation of talk until the end of the treatment/advice-giving phase.

Extract 1 represents the typical way these sequences unfold: alignment and lack of overt patient resistance (extract 1a, also in appendix D, is another example). Extract 2 is the deviant case described above. Each extract suggests a broad range of themes for analysis but I focus on

discussing how the patient presents his/her view and the extent to which the doctor's response builds up an environment conducive to advice-giving and recommendations. I show that the doctor orients to the production of his own opinion on treatment as an institutional task and introduces it at some point in the talk, even if it is in disagreement with the patient. Where the doctor and patient are in agreement, further treatment proposals can be introduced within a framework of alignment. However, if the doctor disagrees with the patient's perspective, this can be seen to create obstacles for eventual agreement as the patient has had an opportunity to state explicitly what he/she does or does not want to happen.

This talk initiating the start of the treatment/advice-giving phase is organised around three stages in which the doctor solicits the patient's view, the patient delivers it and the doctor produces his own. This has similarities with perspective display sequences (PDS) described by Maynard (1989, 1991, 1992; see below). However, I do not describe my data as perspective display sequences as, unlike Maynard's cases, they are not composed of a succinct three-turn sequence. Instead, they are long sequences each made up of multiple actions. Nevertheless, I draw on some of Maynard's relevant insights and demonstrate the consequences of soliciting another's opinion before delivering one's own for this particular stage of the encounter.

7.4.1: Soliciting the patient's opinion on treatment

This section analyses the doctor questions that initiate the start of the phase. In each case, the question invites the patient to display his/her opinion on how treatment should proceed.

Extract 1: Brenda WMC Jan 31st. Lines 1-3. (pp. 76-77 in appendix D)

So far in the consultation the patient has reported feeling stressed at work, causing her to eat more and probably gain weight (see appendix B p. 22). She and the doctor have discussed her sibutramine prescription, a gradual improvement to a knee condition and the possibility of a dietician appointment. The weighing examination recorded an increase in the patient's weight, leading to discussion over what might have caused this. In the moments before the extract begins the doctor has been writing in his notes.

↑

```
1.   Doc:      Ri:ght. So:: (0.4) I guessuh (0.8) wuh
2.             (0.6) from you:r point of view wha:t
```

↓

3.   (0.9)<u>whe</u>re do you see we go from he::r<u>e</u>:

In line 1 the doctor says "Ri<u>:</u>ght. So<u>:</u>:", whilst looking at his notes. The "Ri<u>:</u>ght" appears to suggest the end of his activity of writing and to foreshadow the start of a new action. The "So<u>:</u>:" is hearable as connecting the oncoming talk to matters previously discussed in the consultation (Bolden, 2006). After a silence of 0.4 seconds the doctor starts then abandons some further talk then asks "from you<u>:</u>r point of view <u>wha:</u>t (0.9) <u>wh</u>ere do you see we go from he<u>:</u>:r<u>e</u>:" (lines 2-3). As he speaks, he transfers his gaze and by the end of the turn is looking directly at the patient. The talk and direction of gaze (Heath, 1984) explicitly mark that he is seeking the patient's opinion. This positions any answer she produces as her own opinion and not necessarily 'fact' or an opinion the doctor would agree with. Highlighting the patient's forthcoming talk as an opinion also hints that the doctor may reciprocate with his own afterwards (Pomeratnz, 1984a). The "go from he<u>:</u>:r<u>e</u>:" implies movement away from something current and towards something new. As it is spoken in a medical setting, it is hearable as referring to the patient's current medical status ("he<u>:</u>:r<u>e</u>:") and soliciting her view on how it could change ("go from he<u>:</u>:r<u>e</u>:") – thereby topicalising treatment. This sense is enhanced by the position of the question following the doctor's announcement of a new action; since the previous actions concerned the examination phase, within the logic of the consultation treatment/advice-giving is the next sequence of the encounter. The use of "we" in line 3 further invokes the medical setting by referencing the doctor and patient. It also positions treatment as a dual activity.

Extract 2: Rupert DOC March 13th. Lines 1-7. (p. 104 in appendix D)

The patient has reported that he is okay health wise but is mentally 'fed up'. He reports that he is still looking for a job and looking after his mother, who is ill (see appendix B pp. 24-27). Financial and time constraints limit his activity and he has had to stop going to the gym because local schools are using it. The doctor has commented that the patient has lost a small amount of weight and the patient has remarked that he feels he has lost more in size. The doctor has just turned the camera back on after conducting a physical examination.

        ↑

```
1.   Doc:       Whe:re do you think we're going?

2.              (.)

3.    Doc:      Whe:re d'you think u:h (0.5) we should go

4.              [from here

5.   Pat:       [.hhh hhh

6.              (0.6)

7.   Doc:       °from your° point uv view
```

             ↓

In lines 1-4 the doctor asks: "Whe:re do you think we're going (.) Whe:re d'you think u:h (0.5) we should go from here" . His gaze is not directed towards the patient until an increment in line 7. The "here" ties the question to the current medical context, whilst the entire question invokes the idea of medically relevant change. In particular, the repair from "we're going" to "should go from here" explicitly marks a need for change. The question is hearable as soliciting the patient's opinion on changes to be made to his health status and makes relevant the issue of treatment. Once again, the question marks that the doctor is seeking the patient's subjective opinion and implies that his own opinion may be different and may be produced subsequently.

In each extract the doctor's question performs two particular functions. Firstly, it starts a new consultation activity. Specifically, it marks the start of the treatment/advice-giving phase. Secondly, it solicits the patient's view of treatment. These requests treat patients as competent to assess their own treatment status and position their opinions as relevant to the consultation. Terms such as "do you think" and "from your point of view" mark the question as seeking the patient's viewpoint whilst also indicating that these subjective views may not be

shared by the doctor. This not only suggests a contrast between an expert medical view and a lay one (Maynard, 1992), it also implies that the doctor may produce his own, possibly differing, view later in the talk (this is made explicit in extract 1a p. 83).

As questions that solicit the patient's opinion and hint that the doctor will produce his own opinion later, these turns share similarities with perspective-display initiations. Perspective-display sequences (PDS) have been analysed extensively by Maynard (1989, 1991 and 1992) in ordinary and institutional settings. Maynard describes the PDS as functioning to deal cautiously with the risks inherent to introducing an opinion into talk. The PDS has three parts. The first, as seen above, initiates a recipient's perspective-display on a relevant topic. This is followed by the recipient's reply, often an assessment, and then usually by the first speaker's reply/assessment. By seeking a recipient's opinion first, the PDS initiator is able to deliver his/her own perspective in a way that accommodates that first opinion, thereby lessening the chances of disagreement.

Maynard notes that the cautious function of the PDS is well-suited to professional-lay interactions since it enables professionals to hear lay people's views on 'sensitive' issues before introducing their own. He observed its use in the diagnosis delivery stage of physician-parent consultations for children with developmental difficulties. Before delivering a diagnosis, the physician would ask the parents a question about the child, such as: "What do you think his/her problem is?" or "How do you think he/she is doing?" Silverman (1997) observed perspective display initiations during advice-giving sequences in HIV counselling. A counsellor would solicit a client's viewpoint on a

particular issue – e.g. "How would you feel about using condoms for the next couple of weeks" (1997: p 161) – enabling him/her to align any oncoming advice to the client's expressed viewpoint.

The doctor's questions in my data occur in different sequential positions to those in the above literature but also function to solicit opinion. They share similarities with the examples of 'marked' questions seen above. A question such as "What you do you think his/her problem is?" assumes that some kind of problem exists and prefers a response that agrees with this stance. Likewise, "How do you feel about using condoms…" can be heard to promote this course of action and is not an overtly neutral question. The questions in my data do not project a preference for any particular treatment change, but they do project a need for change. Terms such as "should go from here" imply that some kind of change is advisable and by extension imply that previous treatments have not been successful. In connection to this, it is noticeable that these opinion solicitations only occurred during consultations in which earlier talk or other actions implied lack of success in the patient's weight loss (and diabetes) progress.

7.4.2: Patient opinion displays

Both patients respond to the doctor's question by referencing treatment. However, their answers are designed very differently.

Extract 1: Brenda WMC 31st. Jan Lines 4-21. (p. 77 in appendix D)

```
4.   Pat:        .hhhh
5.               (0.2)
```

```
6.  Pat:      E::rm I ca:n't (0.3) ahm (.) really

7.            happy about going to see: (0.5) the

8.            nutrition[ist, to have a

9.  Doc:               [°Debra°

10. Pat:      look at .hh what my diet i:s, to see

11.           where I'm actually going wrong [becus .hh

12. Doc:                                       [°kay°

13. Pat:      I don't eat >a lot uh< dairy products, I

14.           don't like them,

15. Doc:      mhm

16. Pat:      so I tend to ea:t quite a lot ov protein,

17. Doc:      Ri:ght.

18. Pat:      a:nd a lot uh veg, no:w whether I ave

19.           tuh uh alter the [way I do that, I don't

20. Doc:                        [°Okay°

21. Pat:      know.
```

In lines 6-8 the patient reports being "really happy" to see the
"nutritionist". This appears to refer to earlier talk about seeing a
dietician and treats the doctor's question as topicalising treatment. The
"really happy" positions the patient as positive about this option and
expresses an opinion that agrees with the doctor.

The doctor provides the name of the dietician (line 9) and the patient
describes the purpose of the meeting (lines 8-11). The inclusion of
"actually" in "where I'm actually going wrong" marks the "going wrong"
as somewhat unexpected to her. Since the lack of success is surprising,
this suggests by extension that she is careful with her diet. The patient
mentions not eating and not liking dairy (lines 13-14) and through "so"
(line 16) positions eating a lot of protein and vegetables as a

consequence of this. She presents herself as aware and in control of her own diet and displays the diet itself as weight loss aware – dairy is commonly understood as high in fat and vegetables as low-calorie. This information supports her surprise that her diet is "going wrong". In lines 18-21 she says: "no:w whether I ave tuh alter the way I do that, I don't know". This admits the possibility that she might need to change her diet and that it may currently not be successful. The "ave tuh" and "don't know" allow for differing (expert) views and admit space for alternatives to be recommended. The "ave tuh" also suggests that if changes are recommended, the patient will follow them as a necessity.

Extract 2: Rupert WMC 13th March. Lines 8-12. (p. 105 in appendix D)

```
8.   Pat:     I'Ve GO:tta u:p (.)up my exercise.
9.            (0.7)
10.  Doc:     mh:mm
11.  Pat:     s'the: uh s'the ang? .hh u[:h
12.  Doc:                             [Do you think
```

After the doctor's increment the patient replies in line 8: "I'Ve GO:tta u:p (.) up my exercise". This orients to the doctor's question as referring to treatment. The patient positions exercise as a treatment option he must do – suggesting obligation and need. Reference to "my" exercise positions it as something he is in control of and combines with the repeated "up" to suggest it is something he is already doing, so he just needs to increase rather than start or restart it. Unlike the previous extract, the patient does not use "I think" or any other marker to qualify his response as personal opinion. Therefore his talk appears to suggest a definite route to success. The turn is spoken with finishing

intonation, suggesting completion but is followed by a long silence and a minimal response from the doctor, indicating that he may be treating the answer as not complete. The patient produces a short, unclear turn in line 11 and the doctor begins a question in overlap (see below).

In both extracts the patient responds to the doctor's question with a turn that references future weight loss activities. Patients treat the question as asking about treatment and treatment changes relevant to their condition. There are some key differences in how 'Brenda' and 'Rupert' produce their responses. Firstly, Brenda marks her response as her own opinion. This mirrors the doctor's opinion markers (but it is noticeable that patients do not mirror the doctor's use of 'we' referring to treatment as a joint activity) and qualifies her opinion to orient to the possibility that different viewpoints may exist, such as the doctor's view. Her talk can be seen to defer to medical opinion and create an environment in which it can be easily introduced. This sense is enhanced by the way she refers to the limits of her knowledge. By marking her response as personal opinion based on limited knowledge, she creates an interactional space where the doctor can relevantly put forward an alternative view and in doing so, suggest a different treatment option.

Brenda also accounts for her answer. She defends her diet as healthy to the best of her knowledge and displays a willingness to change if necessary. This account performs similar actions to those observed in chapter 5; it distances the patient from lack of success in weight loss whilst positioning her as knowledgeable about her condition, willing to become well and wiling to cooperate with medical advice. The logical extension of this is that she is willing to listen to any forthcoming

advice or recommendations. The account therefore helps establish a positive environment for advice-giving or treatment recommendations. It combines with her admissions of limited knowledge to suggest that she is open to, or even soliciting, medical advice.

The response from Rupert contains neither opinion markers nor an account. Instead, he designs his response to display definitely necessary action, not an accountable personal opinion. As such the talk does not actively create an environment conducive to advice-giving. In fact, Rupert's response is not in keeping with the account he produced at the start of the encounter. There he positioned external obstacles as preventing him exercising, but here he proposes exercise as a treatment solution. As described below, these differences have particular consequences for the talk that follows.

7.4.3: The doctor's response to the patient's opinion and the development of further talk

So far I have discussed the doctor's opinion-soliciting questions and each patient's responses to them. Now I describe the talk that follows these responses. Of the various interesting themes in this talk, I focus on the extent to which the doctor and patient align over the patient's expressed views. I consider the consequences this has for the introduction of the doctor's own opinion and any further treatment recommendations.

Extract 1: Brenda WMC 31st Jan. Lines 22-88. (pp. 77-79 in appendix D)

The doctor's positive alignment creates an environment in which his medically expert opinion becomes relevant.

Lines 22-42

From lines 22-42 the doctor produces a long turn that ultimately solicits further opinion from the patient. He describes the patient being very active as a "very g<u>oo</u>d start" and says that it is something the dietician will talk to her about. He then praises the dietician, lists some of the things she will discuss and expresses a positive expectation about the meeting, saying he is sure it will help "re<u>vi</u>talise things" (line 38). With this talk the doctor aligns with the patient's positive stance about the dietician and her talk earlier in the consultation about increasing her activity. His following question – "Is there anythi:ng e:lse which you've uh had a (.) <u>th</u>ink abou:t, anything else which i:s .hh any other <u>way</u>z you cun think u:f (.) in <u>te</u>rms u:v .hhh uh ways <u>fo</u>rward here?" – requests another opinion display from the patient on the topic of treatment. In combination with the doctor's previous alignment, the repeated "anything else" and the "any other <u>way</u>z" can be heard to request further information to add to what the patient has already said, rather than to replace it. It treats her previous answer as incomplete rather than wrong.

Lines 43-88

In lines 43-70 the patient produces another opinion. She tells the doctor that she has been thinking about his mention of surgery and states that she is still thinking about it but wants to see where she goes with her diet and "what ave you" first. After some talk about patients chatting in the waiting area, the doctor takes a turn which assesses the patient's treatment needs.

The lip smack and 'okay' at the start of line 72 suggest that the doctor is treating the patient's talk as now complete and that he is about to perform a new action. The "from <u>my</u> point of view I guessuh" (lines 72-73) marks that he is about to produce his own opinion and positions the talk that follows as his own (expert) view. He goes on: "it <u>sou</u>nds as if wuh we're getting the <u>ba</u>sic buh the basic <u>bui</u>lding blocks are <u>fa</u>lling .hh into <u>pla::</u>suh" (lines 74-77). This performs a general, overall assessment of the patient's potential progress and therefore includes the treatment changes that have already been discussed. As a positive assessment it affiliates with the suggestions the patient has made, treating them as sufficient to ensure progress. In line 79 "in terms of" introduces specific examples of how the building blocks are falling into place: seeing the dietician and increasing activity. This explicitly agrees with the patient's suggestions, including the patient's talk about seeing the dietician in her first answer.

The doctor continues "<u>the</u>:n (0.4) the next layer above that issin terms of <u>me</u>dication" (lines 87-88). This introduces a new topic to the consultation and specifically introduces a new treatment option: medication. The design of the turn positions medication as logically

connected to the issues already discussed. This is achieved by mentioning medication immediately after talk about other treatment options and connecting them through "the:n (0.4) the next layer", creating the image of a variety of treatments working together at different levels. Medication is suggested to build on rather than replace the treatments the patient has already mentioned and agreed to undertake. It therefore does not disrupt the environment of alignment that has been built up. This talk precedes a long description of the medications available (see appendix D pp. 79-80) and enables the doctor to introduce medication as a new treatment option in a manner that does not discount the suggestions the patient has already made.

In this extract the doctor solicits the patient's opinion on treatment twice before introducing his own. He aligns with her initial suggestions and treats them as incomplete rather than wrong when soliciting further talk. He then produces his own opinion and constructs it as connected to and in keeping with hers. His talk shares several features of the 'bilateral' approach to decision-making observed by Collins, Drew, Watt and Entwistle (2005). In particular, the doctor presents the decision over treatment changes as still to be made, works to accommodate the patient's perspective and 'signposts' that new treatment options are about to be presented.

The extract can be seen to share similarities with perspective display sequences – with the patient's opinion providing the second part of the sequence and the doctor's opinion completing it. In his analysis, Maynard (1992) noted that soliciting parents' views on what was 'wrong' with their child enabled practitioners to incorporate those views into diagnosis-giving. Following the parent's perspective-display the

practitioner would produce a diagnosis designed to take the parents' views into account and to maximise points of agreement between the participants. Agreements enabled subsequent talk to develop the topic further and gave practitioners the opportunity to deliver the bad news of diagnosis "as in agreement with what recipients know and believe" (1992: p. 355). The doctor's talk here performs similar actions. His second opinion solicitation is prefaced with positive talk about the dietician visit and his opinion giving begins with a positive assessment of the changes the patient has mentioned. He does not take up her postponement of a decision about surgery and therefore appears to treat it as unproblematic. His talk also aligns with her account for her diet as basically fine but in need of some professional input. His treatment recommendation maintains this framework of alignment by positioning medication as an extension rather than replacement of her proposed activities. Just as the patient expressed her opinion with an orientation to a medical viewpoint, the doctor's orients to the patient's view and indicates that he is taking her opinions into account. The doctor and patient establish a positive interactional environment for the discussion of sensitive issues about treatment. By contrast, the talk between the doctor and 'Rupert' is characterised by non-alignment.

Extract 2: Rupert DOC 13th March. Lines 12-259 (pp. 105-113 in appendix D)

The doctor responds to the patient's treatment proposal with a series of questions and statements that treat it with scepticism, but do not reject it overtly. The patient maintains his preference for exercise. After the patient agrees with the doctor's negative assessment of his progress, the doctor re-topicalises the question of treatment.

Lines 12-15

In lines 12-13 the doctor responds to the patient's talk about upping his exercise: "Do you think that that's <u>ac</u>hievable?" As with Brenda, this question solicits further opinion and treats the patient's prior response as incomplete in some way. However, here it refers to a particular part of the patient's response. By asking if the patient thinks his plan to exercise is achievable, the doctor implies that there are grounds for scepticism about it that the patient has not yet addressed. The "Do you think" treats the patient as competent to assess the achievability. The doctor adds: "Becus yuh you know you're looking after yer MO<u>:</u>:ther, it's .hh must be quite tough at the <u>mo</u>ment" (lines 13-15). As marked by the "you know", this repeats information the patient reported earlier. By repeating it the doctor accounts for his question, providing reasons why the patient may not be able to exercise. This talk also demonstrates that he has been listening to the patient and is aware of the problems he has been having whilst implying that what he has heard is inconsistent with the exercise proposal. In this way the doctor appears to align with the patient's overall status whilst questioning the plan he has proposed.

Lines 16 – 43

In lines 16-43 the patient produces more talk in favour of his plan and an environment of non-alignment is established.

After an in-breath and "hu:h" the patient begins a response with "yeh is it <u>is</u>" (line 16). The "it" is hearable as a replacement term for the doctor's "tough" (line 15) so his talk appears to agree with the doctor's

reference to it being difficult for the patient at the moment. The following "but" marks a contrast with this agreement and following some abandoned talk and a 0.3 second pause the patient says "I don't want tuh go do:wn the medic<u>ca</u>tion route." (lines 16-18). The turn carries a sense that however hard exercise is, it is preferable to taking medication. Medication has not been mentioned in the consultation until now, although it is likely to have been talked about in previous ones, and is relevant to the current discussion as a possible treatment. Here the patient demonstrates awareness of available treatments, building his status as knowledgeable. By stating that he doesn't "want" medication, he positions treatment as something he can express a preference about. With this talk, he actively resists taking medication, even though it hasn't actually been proposed by the doctor. It may be possible that the patient has treated the doctor's scepticism about exercise as a move towards recommending medication so his turn pre-empts this move. This sense is enhanced by the delay prefacing the patient's turn, which suggests he is about to produce a dispreferred response.

After a 0.7 second silence the patient accounts for his rejection of medication in lines 20-21. He says that he would "<u>so</u>oner" get rid of it "<u>na</u>turalle:y", implying that exercise is a natural means of weight loss whilst drugs are not. The subsequent "if I can" can be heard to introduce doubt over whether he can achieve weight loss naturally, and by extension whether his exercise will be successful. Alternatively it could suggest that he wants to try exercise first but is not rejecting medication outright.

After a 0.5 second silence and some unclear vocalisations from the patient, the doctor asks: 'ANd d'you think? How do̲able do you think that is̲' (lines 24-25). The repair from an apparent "do you" to a "how" question avoids a repeat of his previous turn and solicits the degree to which the patient thinks exercise/losing weight naturally is doable. The question solicits more information from the patient and treats his previous answer as insufficient. It maintains the doctor's scepticism about the patient's assertions.

After a pause of 0.9 seconds the patient says "u::hm". The doctor produces some unclear talk in line 28 which is followed by a 2.4 second silence. This represents a considerable amount of time in which the patient does not produce an answer to the question. This delay could foreshadow a dispreferred response, or display that the patient is 'thinking carefully' about his answer. In line 30 the doctor says "If you CA:̲n uh I'd be re̲ally happy." This comments on the patient's plan to lose weight naturally and its grammatical construction is interesting in relation to how far the doctor treats it as possible. The "if" sets up a conditional statement and immediately treats success as hypothetical not definite, but the use of the present tense modal "can" projects a first conditional statement, which treats the object action as possible. By contrast, the second clause uses a past tense modal 'would'. This completes the turn as a second conditional, representing a future event as possible but unlikely. This mixed conditional form agrees with the patient's suggestion to the extent that it admits it as a possibility, but it also maintains the established scepticism. The entire statement positions the doctor as not against losing weight naturally but cautious about whether it can be achieved in this instance. The "re̲ally happy"

suggests that the doctor has a subjective involvement in the treatment outcome.

The patient responds in lines 32-33. After repairs he qualifies his oncoming statement as a personal opinion, "ah think". After other delays he states "say a <u>si</u>xty <u>fo</u>rty (do it)". The "say" suggests a general rather than definite estimate. A sixty-forty split is positive one, but minimally so. When speaking in divisions of 10%, it is the lowest possible positive. As an estimate of chances of success, this does not sound particularly promising. But it does align with the doctor's scepticism and is in keeping with the patient's own talk about the obstacles preventing him exercising whilst maintaining his position in favour of exercise. The doctor acknowledges this talk in line 34, the patient responds in line 35 and then begins a long turn in line 37 after a 0.5 second silence. The patient acknowledges the expressed possibility of success as "Marginal" and says "I think? (0.7) <u>if</u> (0.9) I can get into: like the: (0.5) e:r (0.5) <u>ro</u>utine realle:y uh uv of just just <u>go</u>ing to the gy<u>:</u>:m". "I think?" marks this as his opinion and the conditional clause appears to set up a statement that if gets into the routine of spending time in the gym he will be successful. However, the second part of the conditional is not completed, creating a sense of ambiguity, and the "<u>if</u>" again suggests the possibility of lack of success. The actual activity for creating success is presented as simple: "just" going to the gym, with an increment in line 43 stating how much time to be spent there.

So far the doctor's responses to the patient's treatment proposal have taken the form of questions which challenge and imply disagreement with it. This is in contrast to extract 1 in which the doctor's second

opinion-soliciting question implied alignment and he then produced his own suggestion as in agreement with her. Rupert aligns with the doctor's talk about exercise being tough but does not alter his overall preference for it. As such the talk produces an environment of non-alignment.

Lines 44 – 162

The talk from lines 44-162 is organised by a series of initiating statements and questions from the doctor with responses from the patient. The doctor provides reasons why exercise may not be achievable but does not state explicit disagreement.

From lines 44 - 69 the doctor makes a series of statements that repeat or summarise things the patient reported earlier to account for his lack of success. They are marked, by tag questions or "you know", as something the patient already knows and can be assumed to agree with. This begins with "But you have <u>ot</u>her commi<u>:</u>tm<u>e</u>:nts (don't you)" (lines 44-45). The "But" counters the patient's previous turn and so appears to disagree with his talk about finding time to exercise. The confirmation seeking "don't you" also functions to qualify this disagreement. Following "ye<u>:</u>a<u>h</u>: but I" from the patient in line 46, suggesting a modified disagreement, the doctor makes a statement about the patient being busier when he gets a job. He connects this to his previous turn through "And", implying another reason why the patient might not be successful. The patient makes a disagreeing response in lines 51-54 then the doctor produces a modified disagreement in lines 57-69 which lists the problems the patient has been having: busy, awful lot on, mother, things, hectic, knee, a lot of

barriers. During this talk the patient makes a series of acknowledgements and one projected disagreement (line 66), then begins a full turn in line 71.

The "YE:ah buh" (line 71) immediately suggests disagreement and is followed by some unfinished talk. The patient then talks about his knee saying he is "qui:te confident" as long as he doesn't do "anything silly" with it. After a 0.5 second pause he completes this with "NOw it's not gonna give in on it" (line 76). Here he makes a qualified positive assessment of his own knee and rejects the doctor's reference to it as a barrier to success.

The doctor's "°kay° so that's your knee:" in line 78 acknowledges the patient's talk and does not reject it. However, the emphasis on "knee:" through stress and sound-stretching indicates that it is only one of a list of problems and that the others remain unresolved. This sense is enhanced by the "bu:t" that immediately follows and the doctor's statement that the patient is caring for his mother. In this contrastive position, the patient looking after his mother is hearable as a barrier to exercise. Once again, it is treated as something the patient already knows and would agree with through a repeated "you know".

After an initial agreement, the patient's "Well" in line 86 suggests that that his agreement is not straightforward. Following a pause, he upgrades this contrast to a disagreement with "Bu:h" then reports that his mother comes to the hospital tomorrow and he hopes they will say that her bleeding has stopped as he thinks her eyesight has been improving. This puts a positive slant on the topic, lessening the extent to which it can be seen as a barrier to success. After an

acknowledgement by the doctor (line 89) the patient continues his positive talk, stating that if the bleeding hasn't stopped he hopes they'll give her some laser treatment and that she wants to be active. In line 104 the doctor overlaps with "Buh EI:ther wa:y she's going to need a a reasonable amount uf support'. This disagreement is modified by "reasonable" but maintains his earlier assertion that the patient will need to help his mother and by extension that he will not have time to exercise.

The doctor continues in line 112, stating that the patient's time will be taken up with that. The patient's next talk is latched on to the end of the doctor's turn, taking the first opportunity to gain the conversational 'floor': "But we have (.) we have got a carer who can come in'. Once again, "But" suggests disagreement and the turn can be heard to supply evidence that his time need not be taken up. In line 118 the doctor asks: "Who currently comes in?" The stress on "currently" contrasts it with the patient's "can", treating it as ambiguous. In lines 120 -130 the patient responds that the carer doesn't come in at the moment but he can do. He then accounts for this by saying he doesn't want to stop his care allowance and "thuh other things". During this talk the doctor makes a number of acknowledgements (122, 125, 127) then asks "Okay >can't he come in< now und when you are there?" (lines 131-132). This turn can be heard to offer a suggestion about how the patient can give himself more time. However, the negative interrogative structure, "can't he" can be heard to assert a challenge (Heritage, 2002) and criticise the patient for not doing everything possible to find time to exercise. In line 133 the patient begins "Well ee Can" then repairs to "ee DO:es" before referring to the carer coming in three times a week. By repairing to state that the carer does come in

currently, the patient treats the doctor's question and possible criticism as unfounded. In response the doctor asks how long the carer comes in for. This aligns with the patient's talk by acknowledging the carer does come in, but the production of another question suggests that this answer was not fully satisfactory.

From lines 138-145 the patient describes what the carer does, talk which does not directly answer the doctor's question about time. In lines 147-149 he sets up a possible future event through a conditional clause. He projects the possibility of arranging to get to the gym at certain times and so connects the current talk to the topic of exercise. In lines 149-151 he accounts for not being able to go to the gym at the moment and then in line 155 switches to talk about finding an alternative gym, saying if he could find one he could ask the carer to come in at certain times. This treats the doctor's questions as querying how he will be able to find time to exercise and providing a solution to these queries. It also positions himself as committed to becoming well and willing to overcome obstacles. Once again, this possibility is expressed in second conditional form, projecting it as possible but not likely, so does not strongly infer success.

The talk in lines 44-162 continues the topic of how far exercise is achievable. Through a series of statements and questions the doctor maintains his scepticism about the patient's treatment proposal and the patient maintains his position in favour of it. There are a number of noteworthy features regarding how this environment of non-alignment is achieved, in particular in terms of how the doctor counters the patient's proposal. Firstly, the doctor's talk challenges the proposal without disagreeing with it directly – in keeping with the structural

preference for agreement. The doctor's statements providing reasons why the patient may not have time to get to the gym and exercise are marked as facts the patient has already reported. This is similar to the rhetorical device of a speaker quoting an adversary's words back to him/her in a manner that supports the first speaker's own argument (Antaki, 2001). It is difficult to disagree with your own previous talk, so this can perform a powerful move in a debate. Secondly, the statements can also be seen as a device to pursue agreement in an environment where interactants hold differing views (Pomerantz, 1984b). By producing a series of statements that the patient cannot disagree with, the doctor 'checks out' the available facts one-by-one and can be heard to attempt to move the patient towards a position in which he cannot disagree with the doctor's viewpoint.

This second device is 'derailed' when the patient introduces a factor unknown to the doctor: his mother's carer. The switch back to questions from line 118 displays that the talk now covers previously non-discussed topics. The questions connect to the mother's carer and noticeably cover personal issues that do not appear to be straightforwardly 'medical'. They can be heard to treat the patient as providing insufficient evidence to show that the carer's visits will give him time to exercise. The "can't he" question/suggestion in lines 131-132 can particularly be heard as critical of the patient and is treated in response as irrelevant – the kind of overt resistance found by Heritage and Sefi (1992). It is also similar to the resistant responses observed by Pilnick and Coleman (2003) when GPs attempt to problematise a patient's personal behaviour (in that instance, smoking) in connection to his/her health status.

After a further question the doctor makes a negative assessment of the patient's status. The patient agrees and the doctor re-topicalises treatment.

In lines 163-164 the doctor asks: "Do you think tha:t's <u>fe</u>asible? I:t'suh <u>do</u>able?" This is a near repeat of his question in lines 12-13 and again treats the patient's plan to exercise – specifically finding an alternative gym and getting his carer to look after his mother – with scepticism. This scepticism is qualified by being packaged as a question, but as a repeated question on a similar topic it treats the patient's previous responses as unconvincing. The patient does not give a yes/no response to the question and instead replies that it depends on what happens the next day with his mother. This response does not confirm his earlier assertion but is consistent with his projections of success in limited terms. In lines 168-173 he extends his answer by talking about his mother's treatment. He responds to a doctor question in lines 176-7 and talks further about past interventions. In line 184 "so<u>:</u> thas so:" projects an upshot or conclusion to the talk and is followed by talk about her future treatment or lack of it. This long response does not explicitly relate to the doctor's question but is hearable as suggesting that if his mother's appointment is successful and she does not need further treatment, he will not need to support her so much and will therefore have time to exercise. This is an equivocal argument that depends on external events. However, the reference to the appointment tomorrow indicates that this equivocation will soon be resolved. Furthermore, it will be resolved by appropriate medical professionals involved in her care – referenced through "the doctor"

(line 168) and "they" (line 185). The combination of this future reference and reference to external medical authority provide a sense that whether the patient will be able to exercise or not is contingent on external factors and will soon be resolved appropriately. In turn this suggests that it need not be discussed now.

After a 0.5 second pause the doctor begins a turn with "What ↑TROub↓les me," (line 189) suggesting an oncoming opinion. The emphasised "↑TROub↓les" suggests an overtly subjective opinion, based on a negative situation. The pause before it is consistent with both a bad news report and a dispreferred response to the patient's previous turn. It may also suggest a change in topic. After a 0.8 second silence the doctor repairs this to "what con<u>ce</u>rns me" (line 191), a less emotive, more institutional term which nevertheless marks some kind of subjective worry. The doctor continues, stating that when he and the patient first met – i.e. had their first consultation– and commenting that they are now "<u>ni</u>ne months on from that" (lines 192-197). As he does so, including in the silence in line 196, he looks in his notes, suggesting that he is taking his information from there and is seeking to be accurate. After another pause, he continues in line 198, "The fi<u>:</u>rst time you <u>ca</u>me", and looks through his notes again. In line 201 ">see where your weight< was" accounts for what he is doing and hints at the direction of his talk. The patient's "I wuz: (.) <u>li</u>ghter (0.3) than I am now" in lines 203-205 hearably completes the doctor's turn. It appears that the doctor's turn projects the direction of talk enabling the patient to complete it.

This talk about the patient's weight is hearable as a kind of 'bad news' report, stating that the patient has gained weight over time and

implying that he is not making successful medical progress. Its delivery is consistent with bad news reports (Maynard, 2003). It is delayed by the doctor's opinion markers and repair and then hinted at rather than produced explicitly in a way that enables the patient to state it himself. In doing so, he displays awareness of his health status, projects alignment with weight gain as a matter of concern and removes the need for the doctor to report it in specific numbers.

After 1.2 seconds, the patient says "tho:," (line 207), suggesting an oncoming contrast to the talk about weight gain. He does not continue his turn and in line 298 the doctor also makes a short, incomplete turn. In line 210 the patient begins a full turn, connecting his weight gain to taking rosiglitazone (an anti-diabetes drug that can cause weight gain through water retention). The "Bu:h-but" marks this as a contrast to the news about the weight gain and the drug's effects are positioned as previously agreed upon: "we did [>sort of< say thut". This accounts for the weight gain as caused by established side-effects and rejects possible blame for it. In the context of the current talk it can be heard to defend against any implication that the patient's gain can be described as an overall treatment failure, necessitating new interventions such as medication. The doctor explicitly accepts the account in lines 213-216 and the patient further defends it in lines 219 - 222.

The doctor accepts this again in line 223 then produces some further talk in lines 225-226. "I gue:ss" signals opinion-giving again and "what worries me," reaffirms his subjective response to the patient's situation. Although the doctor has accepted the patient's account, this talk indicates that he does not treat it as a sufficient reason not to

worry about the weight gain. This projects but delays a negative report and again the patient comes in to complete the turn. "<u>S</u>lippery <u>s</u>lope' (line 228) conveys that the initial gain may lead to further gains and become a significant problem. This completes a negative assessment of the patient's prospects. In completing the negative part of the turn himself, the patient projects alignment with the doctor's view. In line 229 the doctor agrees and in line 230 the patient makes an acknowledgement. After a 1.6 second pause the doctor says "We're <u>jus</u> <u>no:</u>t making the <u>pr</u>ogress we need to ma<u>:</u>ke". This is hearable as an overall assessment of the patient's treatment progress and completes the assessment first projected in line 189. The repeated "we" constructs the lack of progress as a joint matter and lessens the extent to which the turn can be heard to blame the patient individually. The "need" presents progress as a necessity rather than a choice and creates a sense of urgency about the patient's treatment needs. By extension, this defends the doctor's non-alignment with the patient's equivocal plans to exercise and may hint at the need for other forms of treatment. The patient produces an immediate agreement in line 234 which is reaffirmed in line 236 and upgraded in line 238. Here he aligns with the doctor's overall assessment of his status.

After a 1.0 second pause the doctor takes a turn that re-topicalises treatment. The "so:, if that's thuh <u>ca</u>se" connects the oncoming talk to the previous agreement. The doctor then lists the goals of the patient's healthcare, summarising them with ">if we try un< keep you <u>he</u>althy" (line 249). Again, "we" orients to treatment as a joint action and lessens possibilities for hearing accusations of blame in the talk. After an acknowledgement from the patient, the doctor begins a turn then restarts to "if tha:t'suh what we're <u>ai</u>ming for". The patient agrees then

says "How duh we <u>ge</u>t there.", once again projecting the completion of the doctor's turn. The doctor repeats this – suggesting co-orientation to this issue – and continues with talk that appears to answer the question, beginning with references to getting healthy and diabetic control.

The doctor's talk from line 189 introduces his assessment of the patient's progress. He does not mention treatment, but instead refers to the bad news of the patient's weight loss. By producing his own negative opinion, he provides an opportunity for the patient to align with it. That alignment then provides an opportunity for the doctor to re-topicalise treatment. The broader disagreements are only suspended rather than resolved: the patient has maintained his preference for exercise and the doctor has maintained his scepticism to it. Noticeably, the doctor's assessment is positioned after talk which indicates that the issue of exercise – the topic of disagreement – cannot be resolved now.

The doctor's negative assessment and subsequent re-topicalisation of treatment provide the expert opinion hinted at in his question in lines 1-4. The patient and doctor's opinion-displays are separated by long sequences of talk so, as noted above, cannot be considered a succinct PDS. Nevertheless, some comparisons can be drawn with Maynard's observations. Maynard (1992) found that where medical practitioners could not agree with parental opinions, they suspended their own perspective-display to attempt to reduce the disparity between the two. This included talk which 'converted' the parents' formulation of the problem in a way that incorporated their viewpoint, for example by suggesting that they had indicated one of a number of the child's medical problems. It also included talk that 'identified' with the parents'

views and demonstrated that practitioners were taking them into account. If accepted, these devices enabled the eventual diagnosis to be delivered in an environment of agreement. In ordinary talk, discussion often moves quickly to a new topic once non-agreement has been established and the PDS initiator may even abandon his/her own perspective-display (Maynard, 1989). However, in the medical setting, practitioners maintained orientation to their institutional task of delivering a diagnosis, even though its production risked interactional tensions (Maynard, 1992).

The talk here can be seen in a similar way. The doctor 'identifies' with the problems the patient is experiencing and with his preference for losing weight naturally. He can also be seen to attempt to 'convert' the patient's formulation of his treatment proposal to a more sceptical stance. However, this is met with patient displays of resistance and knowledge and the patient does not change his position. The doctor's eventual opinion-giving can be seen as a device to secure agreement. It does not take up the contentious issue of treatment but instead makes a negative assessment of the patient's progress and maintains it even after the patient's attempt to modify it. Using recorded evidence (the notes) and marking the talk as his own view, the doctor positions the assessment as expert opinion, including his subjective reaction to the patient's situation. Since practitioners are generally expected to be neutral and emotionally uninvolved, the use of "worries" and "concerns" strengthens the negative assessment: if the doctor is worried then it must be bad. This functions as a kind of appeal to medical authority (Pilnick, 2008) and is difficult for the patient to counter. The doctor is then able to use the patient's agreement as an opportunity to re-topicalise treatment and report possible options

himself. The agreement creates a more positive environment for treatment discussion, but does not guarantee that the talk will now proceed without tension. In fact potential difficulties are evident since the doctor and patient have now entrenched their opposing positions and the patient has explicitly rejected medication.

7.5: Discussion

This chapter has focussed on the treatment/advice-giving phase of consultations in the Diabetes and Obesity Clinic and the Weight Management Clinic. As described above, this phase typically involves activities such as suggestions and discussions of treatment options, questions and opinion giving. Most often, agreement over treatment is reached relatively unproblematically and the consultation moves on to the closing phase. I observed a number of ways in which the treatment/advice-giving was initiated – including its emergence through prior talk in the examination phase and through mention of a particular treatment intervention. I selected to analyse cases in which the phase was initiated by a question from the doctor soliciting the patient's views on treatment change. I noted that this device only occurred in consultations where earlier talk or other actions had implied lack of success in the patient's progress. The questions do not refer to any particular treatment options but do orient to the need for change and therefore suggest that the patient has not been making sufficient progress.

I described two different extracts in detail. In my initital observations, the first of these extracts appeared to be a 'typical' case in which agreement was reached relatively quicky, but the other appeared to be

characterised by non-alignment in which the doctor 'challenged' the patient's treatment proposal and the patient 'resisted' the doctor's suggestions, leading to tension in the talk. In extract 1, the patient's answer aligns with the doctor's earlier mention of seeing a dietician and acknowledges that her diet might need to change. The patient also accounts for herself as careful with her diet and willing to listen to medical advice. In response the doctor aligns with her position and introduces medication as a logical extension of the changes she has already suggested. In extract 2, the patient suggests increasing his exercise without an account or any deference to medical opinion. In response the doctor takes a series of turns that question whether the exercise can be achieved, before introducing a negative assessment of the patient's status. The patient agrees with this assessment and the doctor then goes on to talk about treatment options. The analysis of these extracts raises various issues of relevance to CA, sociology and healthcare practice.

My analysis shows that the talk in these extracts is organised around three stages in which the doctor solicits the patient's view on treatment, the patient delivers it and the doctor ultimately produces his own opinion. This has relevance to CA as it indicates how this organising device (which shares some similarities with perspective-display sequences) can be seen as adapted to undertake particular institutional tasks of the setting. The device appears relevant to the treatment/advice-giving phase in general as well as to the particular dymnamics of the consultations in which they occur. The initiating questions explicitly and efficiently begin the phase and solicit patient opinion on treatment change. They also imply the need for change and, as noted above, are produced in consultations where patients appear to

have been unsuccessful in their weight loss and/or diabetes progress. As such, the questions provide an opportunity for patients to acknowledge their lack of success and need for treatment change and for the doctor to avoid stating it explicitly at this point in the consultation. However, these kinds of questions are not always delivered in consultations with 'unsuccessful' patients and further analysis coud usefully investigate why they occur in some cases and not others.

In both extracts the doctor postpones producing his own opinion to solicit further information with talk that refers back in some way to the perspective the patient has produced. This enables the doctor to find out what patients know and believe about their treatment needs before he produces his opinion. This creates an opportunity for him to incorporate the patient's views into his talk and produce an expert medical view that aligns with elements of the previous lay one. In responding to the doctor's question, patients are able to express their treatment preferences in their own terms. Although these turns are responsive they also perform a first assessment and so are initiating actions. This provides a chance to reject a treatment before it has been mentioned by the doctor and therefore produce a turn that is actively resistant.

Following the patient's response, the doctor is in a position to align or not with the patient. Where alignment occurs, this creates a promising environment for advice-giving and medical recommendations. This alignment is not merely contingent on whether the doctor views the patient's suggestions as 'right'. In extract 1, Brenda's acknowledgement of lack of success and deference to medical opinion

can be seen to work up her status as problematic and therefore establish the relevance of advice-giving. Her talk not only aligns with the doctor's talk (about the dietician) it also aligns with medical expertise in general and so positions her as prepared for advice, enabling alignment from the doctor. By contrast Rupert's answer does not include these features and so does not position him as ready for medical advice. Despite this, the doctor orients to the institutional task of giving his own opinion on treatment and his following questions and statements can be seen as attempts to move the patient towards a sceptical, medical stance whilst delaying the start of his negative assessment. The talk that goes on here conveys disagreement between the doctor and patient but nevertheless orients to the structural preference for agreement, since the disagreements are modified rather than explicitly stated. The doctor's eventual negative assessment appeals to medical authority and secures patient agreement. However, this does not create a promising environment for further discussion as the doctor and patient have not relinquished their differing positions. The doctor's orientation to giving his own opinion as an institutional task can be seen to create negative consequences for the subsequent talk.

The analysis shows that these sequences are achieved collaboratively by the doctor and patient. This adds to sociological understanding of medical treatment discussions. In particular it shows that the talk in these discussions can be largely accounted for with reference to interactional norms, without necessitating external references, such as concepts of structural medical dominance. When patients reply to doctor questions/statements, as in much of extract 2, they may seem 'passive' as they are performing responsive actions. However, when

producing their own opinions, they perform initiating actions which make relevant a response from the doctor. This provides an opportunity for patients to state explicitly what treatment they do and do not want. In extract 2, Rupert actively resists medication and the doctor works to alter the patient's expressed view rather than rejecting it, thereby orienting to the treatment decision as a joint responsibility. In fact, as the transcript in the appendix shows, the doctor and patient ultimately agree that the patient will pursue exercise rather than medication and make a 'deal' about how much exercise he will undertake. The patient's own view prevails. Before that occurs, much of the talk covers personal matters such as the patient's mother and her carer and at times the doctor can be heard to imply criticism of the patient for not demonstrating sufficient commitment to finding time to exercise. This kind of talk can be seen as an example of the 'intrusive' practice of social medicine described by Silverman (1987; see chapter 4) in which talk covers non-medical issues and the patient is held accountable for his/her actions. However, where Silverman attributes this to the surveillance power of medicine, my analysis indicates it emerges through the talk itself. The topics of the doctor's questions – mother, job, knee etc are first introduced by the patient and the doctor's scepticism towards the patient's plan can be heard to highlight a discrepancy between his exercise proposal and his original account for limited progress which reported barriers to exercise.

As in the previous data chapters, the analysis also shows that patients present themselves as 'good' in line with sick role (Parsons, 1956: 1975) requirements: willing to get well; receptive to expert help; and not responsible for lack of success. These displays build up an environment in which medical advice and recommendations are

relevant and likely to be well received. This kind of talk can be seen as directly relevant to achieving treatment decisions and is therefore central to patienthood.

The analysis also raises issues relevant to healthcare delivery. Soliciting patient opinion provides a means to start the treatment/advice-giving phase explicitly and directly. It also provides an opportunity for patients to give their own opinions and treats them as competent to assess their own treatment needs. This can therefore provide a way to practise patient-centred medicine and meet NICE guidance (2006) requirements about engaging with obese patients and negotiating with them about treatment. However, when patients produce opinions that the practitioner does not agree with, the ensuing negotiations can be characterised by tension and disagreement. The doctor's talk in extract 2 picks up on the patient's account for his lack of success and challenges his treatment proposal. This can be seen as a practical example of another NICE requirement: getting patients to display their commitment to becoming well. However, as the extract shows, this can be interactionally difficult, creating tension in the talk and leading to resistance when suggestions can be heard as criticisms. As developed further in the discussion chapter, it may be useful for practitioners to be aware of the very different outcomes that the same interactional device when selecting to use them in consultations. Overall, the analysis shows that these types of guideline tend to simplify the conversational practices that occur in consultations and do not account for the ways in which apparently positive or 'empowering' techniques can have very varying outcomes.

Chapter 8: Verbal and non-vocal actions initiating a shift into closing

8.1: Introduction

This chapter investigates closing sequences in the fieldwork clinics. Relevant conversation analytic literature suggests that a variety of interactional devices may initiate closings in medical encounters but that complications may arise if the patient's problem is seen to be not sufficiently 'managed' in some way. The analysis focuses on describing the different types of action that are treated as making relevant the end of the consultation and responded to with a verbal and/or non-vocal move into closing. I show that moves into closing are initiated through a variety of actions, including some not previously observed in the literature on medical interactions. I also observe that non-vocal activities play a key role in these sequences, both in combination with vocal utterances and by themselves. My analysis offers a unique contribution to CA by describing closings in secondary rather than primary care encounters and indicating that the ways in which these interactions unfold may be relevant to certain features of the setting, including the long-term, chronic conditions dealt with in the clinics. In my discussion I draw out the implications of these findings for the understanding of how the interactional process of closing occurs in a medical context.

8.2: Closings and closing relevant environments

Consideration of closing sequences in medical encounters begins with insights from the conversation analysis of ordinary talk. In their seminal work on telephone calls, Schegloff and Sacks (1973) describe an archetypal four turn closing sequence. In the first two turns callers exchange terms such as "okay" and "alright". These offer no new topics of talk and suggest that all prior topics are now complete. As such, they display the relevance of closing. In the final turns, speakers exchange terminal components such as "goodbye". This suspends turn-taking organisation, meaning that one speaker's completed talk is no longer hearable as making relevant a turn from another. Schegloff and Sacks note that in order to successfully close talk, these turns need to occur in a 'closing relevant environment'. This is an interactional environment which suggests that all previous topics are complete, no new talk is forthcoming and that closing is therefore appropriate. Closing relevant environments can be established through a variety of interactional devices. References to future actions, in particular future arrangements, indicate that all current activities have been completed and talk need not continue. Proverbs and aphorisms (Sacks and Schegloff, 1973; Button 1987) and figurative expressions (Drew and Holt, 1998) can function to comment on previous topics in a general way that is difficult to disagree with. They establish the relevance of closing by implying there is nothing specific or noteworthy to add. Similarly, summary assessments (Button, 1987) suggest there is nothing new or specific to say about a current topic and thereby imply the relevance of closing.

Closings in face-to-face encounters involve additional issues to those in telephone calls, since they frequently involve the end of physical proximity as well as verbal activity. LeBaron and Jones (2002) observe that non-vocal/visual actions, such as gaze, body position, and the suspension or (re)start of physical activities, accomplish some of the interactional 'work' involved in closing these encounters. Existing CA studies also note the role of non-vocal actions in accomplishing/enabling different activities in medical encounters (e.g., Heath, 1984; Robinson, 1998; Robinson and Stivers, 2001; Ruusuvuori, 2001), including in closing sequences.

In his video analyses of UK General Practice consultations, Heath (1980 and 1986: 128-134) observed a recurrent pattern that connected the practitioner's talk to the patient's physical and verbal move into closing. He noted that since patients attend to discuss some kind of medical problem, the practitioner is *"obliged to offer some form of help to the patient with whom he is faced"* (1986:129). Practitioners fulfil this obligation by providing appropriate problem management. In the General Practice context this generally involves advice or instruction-giving, suggesting follow-up appointments and writing prescriptions. This management provision is relevant to the closing of the consultation. At some point, the practitioner produced an utterance that treated the patient's problem as 'managed-for-now'; for example, by presenting a prescription. This talk was hearable as a 'management proposal' indicating the completion of the business of the consultation and therefore suggesting the relevance of closing. Patients' responses would accept or decline the management proposal and the implied end to the consultation. Patient acceptances were routinely accompanied by a shift in the patient's body position. As the interaction continued, the

patient proceeded with the process of physically taking leave of the doctor so that by the time terminal greetings were exchanged the patient was near the door and ready to leave the room.

In a study of US primary care, Robinson (2001b) unpacks the concept of 'management proposals' and considers what types of verbal utterances may be accepted by patients as initiating a move into the close of the consultation. Robinson observes that the completion of various institutional tasks, such as handing over forms, making follow-up appointments and issuing treatment instructions, can be seen as 'possibly last topics' in the consultation, establishing a closing relevant environment. In this environment, other turns can be heard as 'designedly last topics' which perform the final activity of the consultation and initiate a move into closing.

Robinson observed two types of practitioner talk on designedly last topics. In one, the practitioner solicited further patient concerns with a question such as "Anything else?" This question conveys that all previously mentioned topics have been dealt with and that the consultation can now close unless the patient expresses some new concern. If patients respond with a (preferred) negative, they confirm the completion of medical business and align with the move into closing. In the second practice, the practitioner proposed a medically relevant future arrangement, such as making a next appointment or waiting to see if a prescribed drug was effective. This talk implied that the patient's problem was managed-for-now and so could be heard to propose the end of the consultation. The patient could then accept or reject the proposed arrangement, and by agreeing would align with closing. Robinson states that it is likely that other interactional devices,

such as figurative expressions and summary assessments, could also initiate a move into medical closings and calls for further research into such sequences.

In a separate study of US primary care consultations, West (2006) observed that making and re-invoking future arrangements were the most common ways in which closings were initiated. She suggests that, in addition to their hearable closing relevant sense, these references may be employed to mark continuity of medical care. She employs Button's (1991) description of how talk can mark an ongoing, or 'standing' relationship between participants and argues that future references convey to the patient that the practitioner's professional interest in his/her care will continue after the interaction finishes. This is an important feature in demonstrating a relationship between practitioner and patient.

In addition to observing how closings in medical consultations routinely occur, studies of medical interaction have also considered issues that may disrupt this activity. Various studies – including Byrne and Long (1976) and West (2006) - have noted the "door-handle remark" or "by the way" phenomenon, apparently much complained of by doctors, in which patients introduce a new medical problem when closings have already been initiated and the patient seems to be in the process of leaving the room. Other studies note that since consultations can be seen as service encounters (ten Have, 1989), certain institutional tasks need to be completed before the meeting can end. This includes the provision of a tangible management solution. Heath (1980) observes that medical encounters are institutionally ordered events and are recognised as such by patients, so that the handover of a prescription

may be an expected feature of closings. If it does not occur, interactional difficulties may arise.

As noted in the previous chapter, Stivers' (2005 a and b) studies of practitioner-parent interactions show that participants in medical encounters orient to agreement over treatment as a necessary action to occur before closing. Stivers observed a connection between parent resistance and the ways treatments were proposed. Parents tended to reject treatment offers that were presented as general and intangible, such as recommendations to "wait and see" what happened. By contrast, they were more likely to accept offers that were presented as specific, immediate and concrete – such as a prescription for antibiotics. Pilnick and Coleman (in press) made similar observations after analysing GP-patient interactions in discussions of smoking cessation in the UK. The study occurred at a time when nicotine replacement therapies were not available on the NHS, meaning that treatment provision tended to take the form of generalised and vague advice-giving, rather than specific medical interventions. They found that this non-specific form of management created difficulties bringing the treatment discussion – and by extension the consultation – to a close. Pilnick and Coleman suggest that these findings may be relevant to medical discussions of other 'lifestyle' conditions, such as obesity and alcohol related illnesses, where specific interventions may not always be available. Indeed, the absence of immediate treatment provision is a major feature of both fieldwork clinics in this study.

8.3: Closings in the DOC and WMC

The literature suggests various themes relevant to my data, such as devices initiating closing and the role of non-vocal actions. However, it also indicates possible points of difference. The above studies describe primary care consultations, predominantly encounters where patients receive care for a new, short-term problem. My data concern secondary care consultations about a chronic condition. The institutional aim of the encounter is to manage the long-term status of the patient's illness rather than provide an immediate solution to it. In any given consultation, there may be no treatment changes to recommend and treatment itself often takes the form of general discussion or advice-giving rather than the provision of specific interventions. Do these differences limit the extent to which the doctor can refer to the patient's problem as managed-for-now and might they be associated with difficulties or delays in closing? Do secondary care consultations or consultations about chronic conditions close in a different way to primary care ones?

The studies highlighting interactional obstacles towards closing appear particularly relevant to my data. As described in chapter 4, the WMC and DOC operated under various institutional constraints at the time of data collection. Significantly, they could not fund weight loss interventions (and some diabetes ones) directly. Instead, the doctor had to make a request to the patient's GP to agree to his recommendations. Consequently, at the close of the consultation patients could not be completely certain of getting the treatment recommended to them by the specialist doctor. The consultations in my data occur in a setting where the handover of a prescription, identified

in other studies as key to problem management, is not possible. Does this influence the conduct of closing, and, if so, how? A final point is that, since the doctor left the hospital at the end of the fieldwork phase, several of the consultations were 'last meetings' in which he informed the patient he would not be seeing them again and that WMC patients would not receive another appointment. Is it possible that these features influenced closings in the clinics? In particular, if closings provide an interactional space for practitioners to mark continuity of care, what are the consequences for the interaction when that continuity is no longer available?

8.4: Findings

Thirty-six examples of closings were found in the data. In the remaining three cases, the camera was switched off before closings occurred. I began the analysis by observing how closing relevant environments were established in the consultations and then focused on how closings themselves were initiated. All the relevant cases were transcribed and analysed. I sought to identify instances of talk that constructed the consultation as now over and that were treated in response as initiating a move into closing. I then characterised the different types of action performed by these turns. My findings show that future references by the doctor were the most common action that initiated a move into closing. However, other verbal actions, including some delivered by the patient, also occurred. These included summary assessments and figurative expressions/truisms. There were also a number of instances where non-vocal actions alone appeared to initiate a move into closing

I begin this section with a description of how closing relevant environments were established in the fieldwork clinics. I then describe the different types of action that initiated a move into closing. Three themes emerge from the analysis. Firstly, observable difficulties in achieving closing are relatively rare. Secondly, moves into closing are initiated by a wider range of actions than observed in previous CA studies. Finally, non-vocal actions play a key role in these sequences. They can enable patients to physically align with closing whilst maintaining a verbal orientation to the consultation as ongoing. They can also enhance the doctor's verbal moves into closing, or even replace them.

The full transcripts are in appendix E (pp. 131-216). As in previous chapters, the transcripts presented here are sometimes shorter extracts of those in the appendix and may begin after line 1. In some cases, relevant prior talk is summarised rather than transcribed.

8.4.1: Establishing a closing relevant environment

As noted above, closings need to occur in a closing relevant environment in order to successfully suspend turn taking organisation. As the first stage of analysis, I observed how closing relevant environments were established in the fieldwork clinics. For reasons of space, relevant transcripts are not presented here. However, two examples (one from each clinic) are shown at the start of appendix E (pp. 131-145). My analysis reveals that closing relevant environments were established over a number of sequences and frequently incorporated the completion of certain institutional tasks. In the DOC, they were established whilst the doctor completed a series of forms: a

yellow prescription request form, a blue next appointment form and a pink form to be attached to the patient's notes. Whilst the doctor was doing this, long silences often occurred, suggesting that previous discussions were now complete. Much of the talk in this period referred to treatment decisions as already made and looked forward to next appointments or the patient's future activities. This treated the business of the current consultation as now mostly complete. The forms themselves had a closing relevant sense as they constructed future events and arrangements. Once completed, the yellow and blue forms were handed over to the patient – sometimes along with forms for further tests – often with minimal explanation by the doctor. The doctor attached the pink form to his notes and often moved them away from him on his desk. The completion of these various tasks can be seen as 'possibly last topics' setting up a closing relevant environment.

In the WMC there were no standard prescription request or next appointment forms. Instead, the doctor often suggested an appointment date and informed the patient he/she would receive a letter about it in the post. Requests for new prescriptions were made in the doctor's routine letter to the patient's GP, which he frequently dictated in front of the patient. This letter reviewed the entire consultation and therefore treated it as complete. Once again, these activities can be seen as 'possibly last topics' establishing a closing relevant environment. This environment was enhanced by the frequent references to future arrangements and treatment activities made during these sequences.

In both clinics, the doctor and patient shook hands with each other, either just before, after or during the verbal initiation of closing. They

also both rose from their chairs and walked to the door, with the doctor typically 'showing' the patient out of the room. Terminal greetings generally incorporated a turn from the patient thanking the doctor in addition to/instead of "goodbye".

8.4.2: Initiating a move into closing

The analysis now focuses on how moves into closing occurred in the fieldwork clinics. I describe actions that were treated by participants as signalling the end of the consultation. Table 8.1 summarises the relevant actions.

Action initiating a move into closing	Number of cases	
Future references	18	
Summary assessments	By doctor: 5	By patient: 6
Figurative expressions/truisms	2	
Soliciting further patient concerns	1	
Non-vocal actions	4	
Total	**36**	

Table 8.1: Actions initiating a move into closings in the fieldwork consultations

This table provides an overview of the actions that initiated a move into closing. As observed in previous studies, future references were the most common action, and referred to a range of future events. There is only one example of the doctor soliciting further patient concerns but some other actions not observed in existing medical CA studies of

closings sequences. Assessments summarising an existing topic or the entire consultation were produced by both the doctor and patient, but in rather different ways. There were also two examples of figurative expressions/truisms. As with these two cases of figurative expressions/trusims, the use of summary assessments has been described in analyses of closings in ordinary talk but not in previous studies of medical consultations. As the extracts below show, these verbal actions were often enhanced by non-vocal actions. This reveals a rather more complex landscape than the table implies, as it may be unclear how far the verbal turns themselves initiate the closing. In four cases closings were initiated by non-vocal actions alone. This tended to occur following some 'trouble' initiating closing verbally. All sequences occurred in the kind of closing relevant environment described above.

In this section, I begin by describing the different types of future references that occurred and consider how they relate to the certain features of patients' continuity of care. I then describe examples of summary assessments and a figurative expression/truism before describing two examples of closings that were initiated by non-vocal actions. I show that, despite the existence of institutional constraints preventing the production of a tangible management proposal, the closings occurred with relative interactional efficiency. Non-vocal actions appear to play a key role in this efficiency and in the accomplishment of these sequences more generally.

Future references

Future references occurred in half the cases. In six cases (all in the DOC) they referred to clinic activities to be conducted immediately after the end of the consultation. Extract 1 is an example.

Extract 1: Kevin DOC 13th Feb (pp. 158-159 in appendix E)

The doctor has handed the patient a next appointment form and some forms for further tests.

↑

```
15. Doc:      if yuh could hand this to the lady
16.           takih took your blood, .hh un ask if
17.           they've got enough uv the sample to
18.           on the blood they've taken already,
19. Wife:     Right.=
20. Pat:      =Ri[:ght.
21. Doc:         [If they ha:e fine un if not we:'ll
22.           have to stab you agai:n .hhhh u:m
```

↑

```
23.            the:: fi:nal thing is don't fo:rget tuh
24.            get yer height mea:sured.
```


↑

```
25.            (0.8) ((Pat makes thumbs up gesture
               towards doc))
26. Wife:      Yeh
27.            (0.3)
28. Pat:       ptck Right. Yes ((Doc and wife stand, pat
               puts hands on arms of his chair))
```

```
29.                  (0.7)
```

                            ↓


```
30.  Wife:      Ri[:ght?

31.  Pat:        [Ooo:::huh ((Pat rises from chair))

32.             (0.8) ((Doc hands pat his gloves))

33.  Wife:      [(°           °)

34.  Pat:       [Thank you very mu:ch sir

35.  Doc:       Nice >tuh see you< Kevin ((Doc and pat

                shake hands))

36.  Pat:       Thank you doctor

37.  Doc:       See you in three months

38.  Wife:      (°           °) ((shaking hands))
```

In lines 15-22 the doctor hands over a blood test form to the patient and explains what to do with it. He then tells the patient to get his height measured (lines 23-24). As noted in chapter 4, patients in the DOC are often asked to undergo further tests such as these immediately after their consultation. This height measuring is explicitly marked as a designedly last topic by "the:: final thing" and its closing sense is enhanced by finishing intonation at the end of the turn. In line

25 the patient makes a 'thumbs up' gesture which appears to function to accept the instruction and its action as a designedly last topic. He then makes a verbal acceptance in line 28 and shifts in his chair, suggesting he is about to stand up in preparation for leaving the room (Heath, 1986). This produces a non-vocal orientation to closing. At the same time the doctor and the patient's wife also begin to stand up. Following this the patient and his wife make physical preparations to leave the room and exchange terminal greetings with the doctor.

In two other cases, the doctor's future reference detailed the patient's next appointment.

Extract 2: Pam DOC 9th Jan (pp. 131-136 and 157-158 in appendix E)

↑
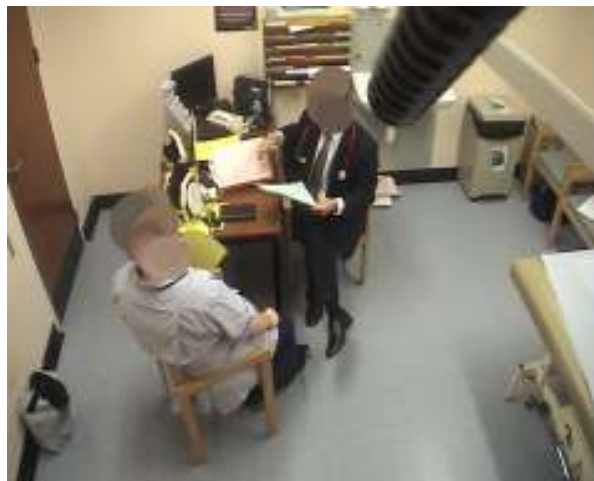
```
79. Doc:     I'd like you to:, >hand this in to

80.          reception,<I'd like to to see [you again

81. Pat:                                  [Yes

82.  Doc:    in four months' ti:me,

83. Pat:     Yeh

84. Doc:     we'll see ho:w the weight's going, >we'll
```

85.   obviously< weigh you on the same sca:les,

86. Pat: Yes

87. Doc: **a::nd we cun take it from there.**

88.   (0.3)

↑

89. Pat: Opefully you'll see some more cha:nge.

↓
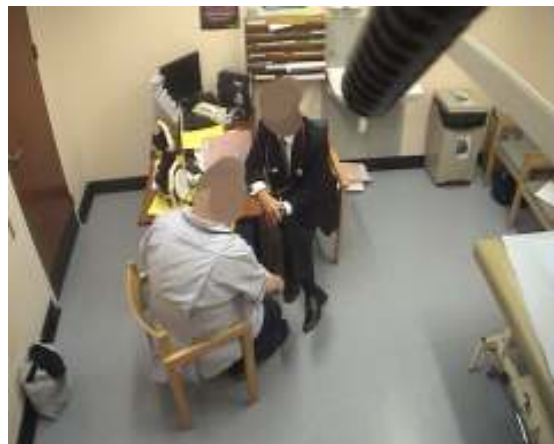
90. Doc: I'm sure I will=

```
91.  Pat:      hehh huhuhuh
```

↓


```
92.            (0.4)

93.  Pat:      .hhh

94.            (4.4)

95.   Doc:     Bye bye Pam=
```

↓


```
96.  Pat:      =Thanking you:
```

In line 79 the doctor holds out the blue form he has been filling in and
instructs the patient to hand it in to reception. In lines 80-87 he refers

to the timing of the patient's next appointment and what will happen during it: "I'd like to see you again in four months ti:me, we'll see ho:w the weight's going,>we'll obviously< weigh you on the same sca:les, a::nd we cun take it from there." Providing details of the future appointment implies that the current meeting is complete. The reference to "weigh you on the same sca:les" refers back to the start of the consultation when the patient complained about her weight recording on the clinic's scales (see chapter 5 extract 12 and appendix B p. 20) This repeated reference has the effect of bringing the consultation 'full circle', suggesting there is nothing new to add. The "take it from there." implies that further changes may be made in the next appointment, contingent on the patient's weight status. This suggests the relevance of future rather than current medical attention. The doctor's talk orients to the patient's condition as managed-for-now and can be heard as a kind of management proposal that makes closing relevant. This sense is enhanced by the finishing intonation at the end of the turn.

The patient produces a series of agreements during this talk (lines 81, 83 and 86) then takes a turn in line 89: "Opefully you'll see some more cha:nge." This aligns with the topic of the next appointment and so implies alignment with the doctor's orientation to the consultation as now over and ready to close. This apparent alignment is enhanced by the finishing intonation at the end of her turn plus her non-vocal actions, as whilst speaking she moves the forms in her hands and starts to shift her body forward, reaching towards her bag on the floor. These actions suggest that she is about to gather up her belongings, ready to leave the room. In the subsequent interaction, the doctor and

patient continue talking whilst rising from their chairs and moving towards the door. Terminal greetings are exchanged in lines 95-96.

In five cases future references invoked treatment arrangements or behaviours away from the clinic themselves. This included references to other medical appointments as well as more general behaviours, as in extract 3.

Extract 3: Becky WMC 25th Oct (pp. 146-147 in appendix E)

```
16.  Doc:       [jus >so we cun see< how the Xenical's
17.             going and so on.
18.             (0.3)
```



```
                      ↑
19.  Pat:       Alright.
20.             (0.7)
21.  Doc:       [And so:
22.  Pat:       [Thas fine.
23.  Doc:       [have a: uh very rabbit christmas
24.  Pat:       [Thank you
25.             (0.3)
```

```
26.  Pat:      Yea:h. O:h yea:h. christmas agai::n.

27.  Mum:      Heh

28.  Pat:      it's A:Llwahhhys [christmas

29.  Mum:                       [huhuhuhuh
                                        ↓
```



```
30.  Pat:      Me birthday's fuh four days before un

31.            a:ll you know .hh hhhhh

                                        ↓
```



```
32.  Mum:      heh heh heh

33.  Doc:      Ha[ppy birthday. ((Doc and pat shake

               hands))

34.  Mum:         [heh heh heh

35.  Pat:      [.hhh Thhhank you:
```

```
36.  Mum:        [heh heh heh heh heh
```

The doctor's talk in lines 16-17 refers to what will happen in the patient's next appointment. The patient acknowledges this in lines 19 and 22. The doctor takes another turn in lines 21 and 23: "And so: have a <u>ve</u>ry <u>ra</u>bbit christmas". The "<u>ra</u>bbit" connects back to the patient's comment earlier in the consultation that in order to lose weight she needs to combine taking Xenical with "eating like a rabbit". The doctor's turn references the patient's future eating, and therefore one of her treatment behaviours. As a future reference it has a closing relevant quality and this is enhanced by the previous talk about the next appointment. As in extract 1, referring back to previous talk also suggests that there is nothing new to be said in the interaction.

The patient's response in lines 26 and 28 aligns with the topic of Christmas. During laughter by the patient's mother the doctor shifts forward in his chair, beginning the process of standing up. In lines 30-31 the patient continues on the same topic and rises from her chair indicating that she is preparing to leave the room and therefore moving into closing. The doctor also stands.

This is one of several cases in which closing quality of talk is enhanced by physical movement. Here the patient's move into closing can be seen to align with the doctor's closing relevant talk and shift in body position. This corresponds with Robinson and Stivers' (2001) observations on transitions between activities in medical consultations (in that study, from history-taking to physical examination). They noted that the physician may orient non-vocally to an oncoming change in activity before announcing it verbally. Patients monitor the

physician's non-vocal actions and may co-orient to the projected transition (non-vocally and/or verbally).

In five cases, the future references occurred when the doctor had told the patient this was the last time they would meet as he was leaving to take up a job in Cleedon. In one case, the doctor referred to the possibility of seeing the patient at one of the Cleedon clinics and in another he talked about the DOC consultant. In the remaining three cases, closings were initiated through a future referencing solicitation, as in extract 4.

Extract 4: Desmond DOC 5th June (pp. 168-170 in appendix E)

As the extract begins, the doctor has a next appointment form in his hand.


```
                          ↑
   1.   Doc:       Ptch >That's tuh hand in tuh reception.<
```

↑

```
2.              It's LOvely tuh see: you again:

3.              [Desmond

4.   Pat:       [Thank you. [And you.

5.   Doc:                   [Be sure you take ca::re.
```


↑

```
6.   Pat:       Good [luck to you

7.   Wife:           [Thank you:

8.              (0.6)

9.   Doc:       Buh bye Lindsay

10.  Wife:      Thanks very much. Chee:rs

11.  Doc:       Nice to see you.
```

In line 1 the doctor hands over the form to the patient and instructs
him to hand it in to the reception. In combination with earlier form

handovers, this establishes a closing relevant environment. In lines 2-3 the doctor offers an appreciation to the patient, stretching out his towards him at the same time. In line 4 the patient responds with "Thank you." and a returned appreciation. The doctor overlaps with "Be sure you take ca::re." whilst the doctor and patient shake hands. The turn references the future in a general way, suggesting that there is nothing specific to address in further talk. It is also the kind of solicitation that may function to soften a move into closing (Button, 1987). These features, plus the finishing intonation at the end of the turn, provide the talk with strong closing sense. As in extract 3, this sense is enhanced by non-vocal actions. The action of shaking hands strongly suggests that the doctor and patient are about to take leave of each other. In line 6 the patient responds with another future referencing solicitation. As he does so, he and the doctor both begin to rise from their chairs and the patient's wife (off camera) says "Thank you". In this position, the wife's turn is hearable as an appreciation for the entire consultation, of the kind often expressed at the end of the encounter. This suggests that the doctor, patient and his wife are all now orienting to closing.

These extracts show the different ways that future references initiated a move into closings. Following West (2006), these various references can be seen to mark continuity of care for the patient. They demonstrate that the patient's treatment will continue, even if it takes place at a different clinic or with a different doctor. More generally, they imply that the patient's continued wellbeing is of interest to the doctor. Since chronic conditions typically require long-term medical attention, this emphasis on continued care can be seen as particularly relevant.

Summary assessments

Summary assessments make closings relevant by commenting on the upshot of a designedly/possibly last topic or the consultation overall. In five cases they were produced by the doctor and responded to by the patient with verbal and/or non-vocal orientation to closing.

Extract 5: Jim WMC 8th Nov (pp. 173-176 in appendix E)

Following the doctor's dictation of his letter to the patient's GP, the patient has offered one correction: he recently took a blood sugar level test but had not understood that it was intended as a fasting test. He had eaten breakfast beforehand so the result was higher than it would have been if he had been fasting. The doctor has re-recorded the relevant part of his letter dictation and his turn in line 1 refers to this test result.

↑

```
1.   Doc:      That's fine then. I'm happy [with

2.   Pat:                                   [That's why

3.             uh

4.   Doc:      [°Yeh°

5.   Pat:      [Yeh (               ) wa:sn't (.) I
```

```
6.              wasn't su:re whether to have a breakfast

7.              uh not, and she sez no:: and I'd had a

8.              .hhh a bo:wl (0.2)a generous bo:wl uv

9.              muesli with nuts and whatever .hh

10.             (0.4)

11. Pat:        I put a handful of bran on the top

12.             un a bana:na.

13.             (.)

14. Pat:        [>every every<day uh the week<

15. Doc:         [°okay°

16. Pat:        [with skimmed milk.

17. Doc:        [That's

18. Doc:        Then that'd be fine then.

19. Pat:        So that's whuh? (                )
```


↑

```
20. Doc:        Fiveuh five point six is no:r[mal

21. Pat:                                      [Yea:h yeah

22.             yeah

23. Doc:        >in that< situation, mine's five point

24.             six at that ti:me

25.             (0.8)
```

↑

```
26.  Pat:      O:kay?

27.  Doc:      Good

28.            (1.6)
```


↑

```
29.  Pat:      So: what uhll we be looking for now?

30.            Another (.) three months or?

31.            (.)

32.  Doc:      Er: I probably (.) uh four months I

33.            [guess.

34.  Pat:      [Yes

35.  Pat:      >Yes okay<

36.  Doc:      okay?
```

```
37.            (0.3)
38.  Doc:      [Wuh
39.  Pat:      [Thanks aga:in
40.            (0.3)
41.  Pat:      Can somebody call me a?
42.  Doc:      Yeah will do.
43.  Pat:      porter please.
```

In line 1 the doctor assesses the test result as "fine". After an overlap in line 2, the patient gives a report on what he'd eaten before the test in lines 5-16. This talk can be heard as a defence of his eating that morning and an account of how 'good' his diet is. The doctor's "Then that'd be fine then" (line 18) re-confirms his assessment without adding anything new to the topic. In response to a patient question he extends his appraisal in line 20, mentioning exact numbers and commenting that his own blood sugar level would be similar at that time of day. This implies that the patient, who has previously been regarded as borderline diabetic, has recorded a similar level to the, presumably 'normal', doctor and so can regard his result as fine. This talk summarises the upshot of the current topic and implies that no more needs to be said about it. Since the topic is an extension of a possibly last activity, the assessment can be heard to make relevant the close of talk about the test and the consultation overall.

During his assessment the doctor begins to rise from his chair and by line 26 has moved closer to the door with his body turned towards the patient. This suggests that he is preparing to show the patient towards the door and enhances the closing sense of the assessment. It strongly suggests that the patient should also prepare to leave the room. In line

26 the patient says "O:kay?". As he speaks he moves his crutches into an upright position, as if ready to put his weight on them. This suggests that the patient is about to stand and provides a hearing of "O:kay?" as soliciting confirmation that the issues of the consultation are now complete. After the doctor's "Good" in line 27, which appears to answer the patient's query, the patient rises from his chair. This physical move aligns with closing. Whilst continuing to stand he asks about the timing of his next appointment (lines 29-30). As a reference to future arrangements this has a closing relevant sense, but it also orients to medical business rather than the ending of the consultation. So to a certain extent the patient verbally treats the business of the consultation as not yet complete even whilst physically aligning with closing. The doctor answers in lines 32-33 and as talk continues the doctor and patient move towards the door.

This extract demonstrates how a summary assessment can initiate a move into closing. It also shows that simultaneous verbal and non-vocal actions can orient to different activities since the patient physically aligns with closing whilst producing talk that treats it as not complete. Although the doctor's orientation strongly prefers patient alignment, the patient is not totally constrained to co-orient to closings. The patient is also able to use the lapse of talk that occurs during movement towards the door as an interactional space to produce new talk. This occurs in a number of cases in my data and includes patient activities such as asking about future arrangements or introducing new concerns.

In six cases summary assessments produced by patients were treated as initiating a move into closing. This occurred in two ways. In one, the

doctor responded to the assessment with a verbal and/or non-vocal move into closing. In the second, the patients treated their own summary assessments as closing relevant by beginning to shift physical position during or just after talk. This is shown in extract 6.

Extract 6: Becky WMC 10th Jan (pp. 191-193 in appendix E)
The patient has recently had bariatric surgery and this topic has been the focus of much of the consultation. As the extract begins the doctor initiates the possibly last action of checking the patient's contact details.

```
1.   Doc:      Have I got your conta:ct (            )

2.             Becky?

3.   Pat:      I've jus to:ld

4.             (0.7)

5.   Doc:      A:nd

6.   Pat:      Thas i:t

7.   Doc:      Yep?

8.   Pat:      Yeah.

9.             (0.7)

10.  Pat:      E:r I've jus told thu:h (.) lady

11.            outsi:de, >don't know< er name,

12.            (0.4)

13.  Doc:      That's Helena

14.            (0.5)

15.  Pat:      Eleena?

16.  Doc:      Helena yeh

17.  Pat:      °(            )° (.) .hhh er::m I jus said

18.            I'd tell anybody tuh go un ave it done.

19.            (0.4)
```

```
20.  Pat:       Suh changed me: in a wee:k

21.            (1.3)

22.  Pat:       An it?

23.            (0.7)
```



```
                 ↑

24.  Pat:       Never thou:ght >anybo:dy be able< tuh

25.             mahke me: feehl full. hehehehehe

                                              ↓
```



```
26.  Doc:       Cum au:gust

27.  Pat:       [.hh huh[huhhuhuh

28.  Mum:       [huhuhuh[uhhuhhuh

29.  Doc:             [Be even more impressive Becky.
```

Following the doctor's question in lines 1-2 the patient moves over to look at and confirm her contact details. In line 10 she restarts a turn projected in line 3. After confirming the name of the "<u>la</u>dy outsi:de" the patient states that she has just told her that she'd "tell <u>an</u>ybody tuh go un ave it done." (lines 17-18). The "it" is hearable as referring to her operation and the turn functions to convey a positive comment about bariatric surgery. The patient makes another positive comment about the operation changing her "in a <u>wee:</u>k" (line 20), with a tag question directed at her mother who is also in the room (line 22). In lines 24-25 she continues her positive talk: "<u>N</u>ever thou<u>:</u>ght>anybo<u>:</u>dy be able< tuh mahke <u>me</u>: feehl <u>fu</u>ll." This references the consequences of the surgery – it has made her feel full so by implication has enabled her to eat less and lose weight. The turn can be heard to summarise the positive upshot of her surgery. As a summary of a possibly last topic, it can also be heard to make closing relevant. The patient treats the talk in this way by beginning to rise from her chair during her laughter at the end of the turn. In line 29 the doctor starts a turn that aligns with the positive talk by projecting further progress. As he does so he also begins to stand, treating the patient's turn and physical movement as initiating a move into closing.

The patient's summary assessment is not produced in response to a doctor turn proposing closing. It can be heard as proposing closing itself and is aligned with as such by the doctor. The use of summary assessments was one way in which patients themselves initiated a move into closing. In each case these turns were treated by the patient as humorous, in contrast to the doctor's close initiating summaries which were not delivered with laughter.

Figurative expressions/trusims

In two consultations closings occurred after the doctor produced figurative expression/truism that summarised the topic at hand. Extract 7 is an example.

Extract 7: David WMC 13th June (pp. 197-199 in appendix E)
This patient has been to Cleedon for a bariatric surgery consultation but requires further tests to assess whether his problems with heart failure will prevent him from having the operation. The doctor has told the patient that he will not have another WMC appointment as the clinic is closing. As the extract begins the doctor and patient are discussing the pros and cons of the surgery.

↑

```
1.  Pat:      W↑uh think if er I .hhh got through the
2.            surgery, tha wuh uh-I could lose the
3.            wei:ght
4.            (0.9)
5.  Doc:      °But° it's a case of how safe is the
6.            sur[gery
```

```
7.   Pat:          [mhm.

8.   Doc:      What [(sort of) risks (is there).

9.   Pat:           [That's it. Yeah

10.          (0.7)

11.  Pat:      .hhh I mean if I >will a:ve< (1.5) TEn

12.           years after the surgery and surv:ive,

13.           fair enou:gh .hhh but if I will ave (0.6)

14.           five years un the surgery I >migh as

15.           well< a:vefuh .hh ten yea:rs and not ave

16.           the suhhrgehhry.

17.          (0.5)
```



```
                                        ↑
18.  Doc:    Ptch that's the pro:blem, you cun you

19.          cun (0.3) can't predict the future

20.  Pat:    We:h that's ri:ght.

21.          (0.4)
```

```
22.  Pat:        WEll thank you very much doc[tor

23.  Doc:                                     [Ptch

24.  Doc:        All the best.

25.             (1.1)
```

↓


```
26.  Doc:        Nice tuh see you.

27.  Pat:        Yea:h nice tuh see you

28.  Doc:        Buh [bye now.

29.  Pat:            [Cheerio
```

From lines 1-16 the doctor and patient discuss the possible surgery.
From lines 11-16 the patient comments on the merits of the surgery in

respect to how long he would be likely to live after it – hearable as a reference to his health problems of obesity and heart failure. The doctor's response in line 18 begins "that's the pro:blem," prefacing what follows as a kind of summary and overall 'truth' of the issue being discussed. The doctor continues "you cun you cun (0.3) ca̲n't predict the future" (lines 18-19).

This completes the projected talk and is hearable as related to the current topic of the patient's wait for test results. It is designed as a particular kind of summary assessment of the patient's situation that delivers the basic 'truth' of the patient's situation using a familiar expression. The truism that you can't predict future implies that the patient cannot predict what will happen to him, at least until he has his test results. This truism could also be heard to imply an aphoristic moral that you should not attempt to predict the future when it cannot be done. As a general comment, the talk treats specific medical details as not now relevant and invoking the idea of waiting suggests that no more action can be taken now. Additionally, as a general truth, it is difficult to disagree with, so suggests that there is no more to be said on the matter. Therefore the turn has a strong closing relevant quality.

In line 20 the patient agrees with the doctor and in line 21 the doctor offers his hand to shake. This physical movement enhances the hearing of the doctor's turn as initiating the close of the consultation. In line 21 the patient thanks the doctor whilst shaking his hand; both his non-vocal and verbal actions align with the suggested move into closing. The doctor and patient then exchange appreciations, a solicitation and terminal greetings whilst rising and moving towards the door.

The use of the expression about predicting the future appears fitted to the particular circumstances of this consultation. The patient will not have another appointment at the clinic so this cannot be referred to in closings. Furthermore, his future weight loss treatment is uncertain, reducing the suitability of references to other future arrangements. The doctor references the patient's medical future, but in a non-specific way. This reference to uncertainty is aligned with by the patient who also co-orients to the closing sense of the turn.

Non-vocal actions

In the above extracts closings are initiated through a combination of verbal and non-vocal actions. In the remaining five cases closings appear to be initiated through non-vocal actions alone. Two examples are presented here and in each case, some kind of 'trouble' in the talk can be observed.

Extract 8: Damian DOC 31st Jan (pp. 200-204 in appendix E)
The doctor has recommended that the patient try a new anti-obesity drug and has dictated a letter to the patient's GP outlining this recommendation. As the extract begins the doctor has just told the patient he will receive a copy of the same letter and that when it arrives he should make an appointment to see his GP and request the drug.

↑

```
25. Pat:      Un then I cun jus tek that to:?

26.           (1.0)

27. Pat:      °me doctor un[:°

28. Doc:                  [doctor Woods und °say°

29.           (0.8)

30. Doc:      look (0.4) ca:n I ha:ve this ta:blet

31.           [plea:se?

32. Wife:     [doctor Imran

33. Pat:      Imran

34.           (.)

35. Pat:      Course

36. Wife:     a:h wuh

37. Pat:      yea:h

38. Doc:      Pick>uh whoever's< easiest of tho:se.

39. Wife:     ea:si[est ih

40. Pat:           [YOU SEE I HAD to go fer a medical

41.           in the week, din uh I on me knee:. Last
```

```
42.              wee:k
```

↓


```
43.  Wife:    Yea:h

44.           (0.5) ((doc stands up))

45.  Pat:     Un all that sorted ou:t.

46.  Wife:    That was (you and me vis[iting)

47.  Pat:                            [Ri:ght go o:n

48.  Pat:     Jan, (eez almost) done.
```

↓


```
49.  Doc:     [(>Gotta get along< Damian)

50.  Wife:    [Yeah I DOn't BLA:me him.
```

```
51. Wife      Ee wuh eh heh heh huh huh [huh

52. Pat:                            [No:w th[en.

53. Wife                                    [(    )
```



```
54.            (        [ending)

55. Pat:              [Right THAnks a LOt anyway

56. Doc:       [Nice to see you

57. Pat:       [Cheers very much. See you later
```



```
58.            (0.5)

59. Wife:     Ri:ght. thank you[:

60. Pat:                        [kay bye:

61.            (.)

62. Wife:     bye:
```

```
63.  Doc:        Bub bye.
```

The patient's talk in lines 25 -27 is treated by the doctor as requesting further information about what he should do when he receives his letter. The doctor's further instruction-giving in lines 28-31 includes a reference to the patient's named GP. In line 32 the patient's wife mentions the name of another doctor and the patient repeats this in line 33. In this position this is hearable as suggesting that the patient see a different GP to the one named by the doctor. In line 38 the doctor tells the patient to pick "whoever's< easiest of tho:se." The patient has spent much of this consultation (and previous ones) complaining about his uncooperative, uninterested GP, so the doctor's turn can be heard to recommend that the patient sees whichever one he believes will be more cooperative. In the context of seeking a drug prescription, the talk can particularly be heard to recommend that the patient sees the GP most likely to agree to the expensive drug. The doctor's turn is spoken with a downward, finishing intonation that suggests he is treating the instruction-giving as now complete.

In lines 40-42 the patient reports having had to go to the GP recently for a check on his knee. He connects this information to his previous turn through the initial "YOU SEE", providing a hearing of his talk as a reference to the lost opportunity of seeing the GP for both things at the same time or to the inconvenience of having to go back again so soon. The patient therefore orients to the business of the consultation as still ongoing. During this turn the patient and his wife direct their gaze towards each other. Meanwhile, the doctor begins to shift his body in a manner that suggests he is about to stand. The wife and patient go on talking on the same topic in lines 43-46 whilst the doctor stands up and

faces the patient. His non-vocal actions are strongly associated with closing but the patient and his wife remain oriented to the business of the consultation.

During the end of the wife's turn in line 46, the patient loudly taps the end of his walking cane on the floor and in lines 47-48 addresses his wife: "Ri:ght, go o:n Jan". During this turn, the doctor extends his hand to the patient and who stretches his out in return. The "Ri:ght", delivered with rising intonation, is hearable as marking the introduction of a sudden change of topic and this sense is enhanced by the patient's previous sudden tap of his cane. The cane tap additionally provides a suggestion that some physical movement might follow. The "go o:n Jan," can subsequently be heard as an instruction to the wife to move on, in the sense of closing the topic and perhaps getting ready to leave. This sense is enhanced by the patient's simultaneous movement of stretching his hand towards the doctor, indicating his is preparing to shake hands. So during this short turn the patient's verbal and physical orientation appears to move away from talk about his GP and towards the relevance of closing.

Whilst the patient shakes the doctor's hand he produces further talk that is unclear but appears to comment on the doctor being "done". This could reference to the doctor having finished the consultation, with the possible double-meaning that he has also 'had enough'. The doctor's turn in line 49 is unclear but possibly accounts for his wanting the consultation to close. In line 50 the patient's wife overlaps with the doctor: "Yeah I DOn't BLA:me him." As a response to the patient's turn, the "him" is hearable as referring to the doctor so that turn may state that she doesn't blame his for wanting the consultation to end.

The jokey sense of her turn is enhanced by her raised volume in "DOn't BLA:me" and her laughter in line 51. During this turn, the wife and patient gather their possessions and begin to rise, so that by the time the wife begins an (unclear) turn in line 53 all the interactants are standing and the patient is turned towards the door. In the following talk appreciations and terminal greetings are exchanged then the patient and his wife leave the room.

In this extract the doctor initiates closing through non-vocal actions by standing up and offering his hand to shake. These actions are carried out without any accompanying verbal proposal of closing but are reciprocated by the patient and his wife almost immediately. This indicates the role of body movement as a resource in initiating closing. The patient and his wife topicalise the business of closing by commenting on the doctor's actions. They treat his physical posture as demonstrating the end of the consultation and treat this as something laughable not rude. It is possible that the doctor's talk in line 37 was delivered as a possible close initiation. His instructions to see the easiest GP available, spoken with finishing intonation, can be heard to present a complete management proposal and therefore invoke the end of the consultation. However, by producing further talk the patient indicates that he is not treating the turn as initiating the close of the encounter. Although his turn is complete in grammatical terms, the doctor's instruction leaves many things uncertain and a number of issues remain unmanaged: it might not be convenient for the patient to see his GP again so soon after seeing him the week before; a GP appointment might not be possible immediately; the preferred GP may not be available; the GP may refuse to produce the prescription. This lack of certainty may be connected to the patient not treating the

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doctor's turn as a complete management proposal initiating the end of the consultation.

Three of the four cases of non-vocal actions were associated with some 'trouble' in the closing. In this extract this trouble is due to the patient not reciprocating the doctor's close initiation by treating the management proposal as not complete. In extract 9, the patient does not co-orient to closing until he has delivered an account for his condition.

Extract 9: Rupert DOC 13th March (pp. 204-210)

This extract shows the closing sequence of the consultation discussed in chapter 7, in which the patient rejected medication and the doctor expressed scepticism about his plan to exercise. The doctor and patient have now made a deal about how much exercise the patient will do before his next appointment (see pp. 124-129 appendix D).

```
30.  Doc:      = >And this is for you to han din to the
31.            receptionist fuh yer next appointment.<
```

↓

```
32.            (0.3)

33. Pat:       Ri::ght (uhn kri)

34.            (0.9)

35. Pat:       uhh

36. Doc:       Good luck

37.            (0.8)

38. Doc:       Un I hope the appoi:ntment tomorrow

39.            goes well

40. Pat:       ye:h.

41.            (.)

42. Pat:       Wuh but? hi::ng

43.            (.)

44. Pat:       (I spuh)

45.            (0.5)

                        ↓
```



```
46. Pat:       Ih uhh
```

↑

```
47.           (1.7)

48.    Pat:  thu:h (.) thuh the sort uf the weight

49.          gain scena:rio,

50.          (0.7)
```

↓


```
51. Doc:      °mh:m°.=

52. Pat:      Rea:lly

53.           (0.7)

54. Pat:      erm.

55.           (1.3)

56. Pat:      Has happene:d (.) probley in the las:

57.           o:hh

58.           (2.3)
```

```
59. Pat:      TWo THree yea:rs

60. Doc:      mh:m.
```

                          ↓


```
61.           (0.9)

62. Pat:      Ri:gh

63.           (.)

64. Pat:      SO:(.) uh:um

65.           (2.8)
```

               ↓   ↓


```
66. Pat:      mhmu:h

67.           (0.5)

68. Pat:      So I was actually sort uf diagno:sed as

69.           (.)diabetic, .h when I came back from the
```

70.   middle ea::st. I didn't <u>kno</u>:w that I was

71.   di<u>abe</u>tic.

                   ↓

72. Doc: >Be Intre<u>:</u>st< tuh see your (.) what your

73.   <u>bl</u>ood test is <u>toda</u>:y actually

74. Pat: Yu:h

75. Doc: °mm.°

76. Pat: So:

77.   (0.9)

78. Doc: Goo<u>:</u>d

79.   0.4)

80. Doc: <u>Th</u>ank >you fer< coming ba<u>:</u>ck

81. Pat: Tha<u>:</u>nk you

82.   (3.3)

83. Doc: Buh b<u>ye</u>: Mister Bennett

                            ↓

84. Pat: Buh

In lines 30-31 the doctor hands the patient an appointment form and instructs him to take it to reception. The end of the turn is spoken with a downward, finishing intonation. The patient produces an acknowledgement in line 33 followed by some unclear talk. In line 36 the doctor says "Good luck". As in extract 4, this is a kind of solicitation that can function to soften a move into closings (Button, 1987). It also makes a general future reference. It implies that the business of the consultation has been concluded and that future events rather than current ones are now relevant. There is no patient uptake to this turn and in lines 38-39 the doctor produces another solicitation referring to the hospital appointment the patient's mother has the next day. Once again, this future reference has a closing relevant quality and its implication that the consultation is complete is enhanced since the talk is not connected to the patient's own treatment.

In line 40 the patient's "Ye:h" appears to acknowledge the doctor's talk. He continues in line 42 with some unclear talk that includes a disjunctive "but?" suggesting he may be making some kind of contrast to the doctor's prior talk or his orientation to the consultation as complete. The patient produces further unclear/incomplete turns in lines 44 and 46. In line 44 the doctor moves his gaze away from the patient and towards his desk. He maintains this gaze in lines 45 and 46 and in line 47 shifts his body backwards, placing the patient's notes behind him. This treats the patient's notes as no longer needed and very strongly indicates that the doctor is orienting to the consultation as complete. After repeated "thuh"s at the start of line 48 the patient produces a clear turn as the doctor's gaze shifts back towards him

(Heath, 1984). The "wei:ght gain scena:rio" is hearable as referring to the patient's own weight gain over time – a topic discussed earlier in the consultation. Spoken with continuing intonation, this turn suggests that the patient is re-topicalising this discussion and therefore treating it, and the consultation overall, as not complete. During his turn he picks up some of his forms, a possible indication that he is gathering his belongings before leaving the room. At the same time the doctor shifts his body weight forward and continues to rise in line 50, a strong physical orientation to closing.

The doctor makes a minimal acknowledgement in line 51 and the patient continues in lines 52-59 describing his weight gain as occurring in the last "TWo THree year:rs". The patient remains in his chair, folding up his forms whilst the doctor stands facing him. The doctor makes another minimal acknowledgement in line 60 and the patient continues in line 62 with "Ri:gh" followed by "SO: (.) uhm" in line 64 which projects an upshot of his previous talk. This is followed by a 2.8 second silence during which the doctor moves towards the door and the patient begins to rise from his chair. By moving to the door the doctor implies that he – and the patient – will soon be walking through it, therefore upgrading his physical orientation to closing. By standing up the patient also physically orients to closing but has so far made no verbal orientation to it. In lines 68-71 the patient accounts for his diabetes as undiagnosed until he returned from working overseas. The doctor remains standing by the door and the patient picks up his jacket, suggesting that he is preparing to leave the room, but does not move over to the door.

In lines 72-73 the doctor says ">Be Intre:st< tuh see your (.) what your bl̲o̲od test is to̲da̲:y actually". The "actually" ties this talk to the patient's prior turn (Clift, 2001) and therefore appears to take up the topic of the weight gain and diabetes. However, the content of the turn does not refer to these issues directly and instead references the future activity of the patient's blood tests. Furthermore, the position of "actually" at the end of the turn can be heard to project a (disjunctive) topic shift from this turn onwards (Clift, 2001). With this turn the doctor takes up the patient's topic minimally and in a way that does not encourage further talk about it. It also projects the relevance of closing through reference to a future arrangement.

After an exchange of agreements/acknowledgements, the patient says "so:" in line 76. As a turn on its own this is hearable as an 'in conversation object' (Button, 1987), designed to solicit new talk and move out of closings. As he speaks the patient is putting on his jacket, maintaining a physical orientation to leaving the room. In line 78 the doctor's "Goo:d" appears to announce the end of the current talk and, in this closing relevant environment, the end of the consultation. He then thanks the patient for coming in line 80, treating the consultation as now over. In line 80 the patient thanks the doctor whilst shaking his hand. This turn is his first verbal orientation to closing. The patient leaves the room whilst terminal greetings are exchanged in lines 83-84.

In this extract the doctor's non-vocal actions initiate closing. As in extract 8 it is possible to see some of the doctor's talk as projecting a move into closing. His handover talk in lines 30-31 is a possibly last topic and is spoken with finishing intonation. It is followed in lines 36 and 38-39 with future referencing solicitations that can function to

soften a move into closings. However, as in extract 8, the patient does not align with the projected closing. He produces a number of turns that account for his health status and remains in his chair for a long time after the doctor stands up. After eventually rising, he does not produce any verbal orientation to closing until the doctor has responded to his account. Both extracts 8 and 9 suggest that not co-orienting to closings provides patients with an opportunity to pursue some alternative agenda for the consultation. This is discussed further below.

8.5: Discussion

This chapter has discussed closing sequences in the fieldwork clinics. In my analysis I described how the completion of certain institutional tasks, such as filling out forms and organising next appointment dates, combined with interactional devices to establish closing relevant environments in the encounter. I then described the different actions that initiated a move into closings in these environments. I showed that future references of various kinds were the most common action initiating a move into closing but that other actions also occurred, specifically: soliciting further patient concerns; summary assessments, figurative expressions/trusims and non-vocal activities. This includes devices observed in existing CA studies of ordinary talk but not previously seen in work on medical interactions. My findings therefore offer a new contribution to CA understanding of closing sequences in medical consultations. In this discussion I draw out the implications of these findings. I discuss how far the closing initiating devices observed in the data may be connected to the particular institutional tasks and

constraints of the setting and I highlight the importance of non-vocal actions in the accomplishment of these sequences.

In over half the consultations in my data, the close of the encounter was initiated by a device observed in existing medical CA studies. There was one example of a question soliciting further patient concerns and 18 future references. These devices can imply that the patient's problem is managed-for-now and convey the relevance of closing. The future references related to a range of upcoming events. Some were specific, such as immediately next activities and future appointments in various settings, whilst others were more general, such as references to treatment behaviours and solicitations for the future. The prevalence of future references suggests that they may be a particularly efficient interactional device to secure closing and also suggests the relevance of West's work on demonstrating continuity of care. The future references in my data indicate the continuity of the patient's care in different ways. References to specific appointments (extract 2) and activities (extract 1) demonstrate that the patient will continue to receive care in the same and/or other clinics. More general references to treatment behaviours (extract 3) or the future (extract 4) indicate that the patient's condition is an ongoing matter and implies that is a continuing matter of concern to the doctor even if he will not meet the patient again. Demonstrating continuity of care may be particularly relevant to the treatment of chronic conditions such as obesity. The obese patient is likely to warrant medical attention for a long period of time, receiving treatment in a variety of medical settings – GP surgery, specialist clinic, operating-theatre and so on. Patients are also expected to carry out their behavioural changes constantly between appointments. Future references can display the constancy of the

patient's condition and treatment, imply the 'connectedness' of treatment across different settings and the doctor's own ongoing concern.

In addition to future references and further concern solicitations, I also observed the use of other actions to initiate closing that have not been observed in previous medical CA studies. Their occurrence in my data may be connected to the fieldwork setting. I observed 2 figurative expressions/truisms and 11 summary assessments of some kind. Both devices operate in the same way as in ordinary talk by summarising the upshot of a current topic or interaction in a way that conveys no more talk is needed or draws out the 'truth' of the current situation. Interestingly, over half the assessments were produced by patients. This indicates that patients can and do employ resources to initiate closings themselves. It is relevant to consider whether their use may connect to the patients' status as chronic patients who have been receiving treatment for their condition, in the clinic and beyond, for a long period of time. As 'expert' patients, they are likely to be aware of the institutional procedures of the clinics and the type of discussions that occur during appointments. For example, the patient's assessment in extract 6 acknowledges her gastric band operation as the main focus of the consultation and treats discussion about it as now complete. Noticeably, all the patients accompanied their assessments with laughter. It would be interesting for further analysis to consider why they might take this particular form. The doctor's assessments and figurative expressions/truisms can also be seen as connected to the conduct of consultations about chronic conditions as well as to the particular constraints of the clinic. In extract 7 the patient's treatment is contingent on the extent of his co-morbidity and he will not be able

to attend the WMC again. Therefore a reference to a specific future event is not possible and orienting to the patient's problem as managed-for-now could be heard as inappropriate. The general, future referencing expression produced by the doctor provides a hearable close orientation that is suited to the context. These findings suggest that closings in secondary care encounters for chronic conditions may indeed vary from those in primary care.

At the start of the analysis I was interested to observe how the institutional constraints might influence the conduct of closing. In particular I was keen to assess whether the absence of prescriptions and the frequency of no treatment changes would create difficulties in bringing the consultation to a close. However, I found relatively few cases of 'trouble'. Instead, closings tended to be accomplished with relative interactional efficiency, occurring over a small number of turns and taking little time. Once an orientation to closing was made, participants tended to align with it quickly. Even when one projected move did not result in closing, (extracts 8 and 9) alternative resources were available to project it again. The relative absence of trouble could once again be connected to patients' 'expert knowledge' of the setting. As routine patients they are likely to be aware of the constraint against prescriptions. Furthermore, as routine patients with chronic conditions they make not expect to receive new treatments on each visit. In fact, an absence of treatment change can be seen as positive, as it is a sign that the patient is making progress. More generally, the absence of trouble can be seen to show the efficiency of the closing relevant devices employed. The use of future references, assessments etc, particularly when combined with non-vocal actions (see below), can project the end of the encounter even if the patient's medical concerns

have not been resolved in a tangible way. Consultations can *end* in interactional terms even if they do not *conclude* in medical ones.

Where trouble did occur, it can be seen to reflect key features of clinic organisation and the status of the medical conditions being treated. In extract 8 the doctor's instruction to the patient to request a new drug from his GP appears to treat the patient's problem as managed-for-now, making closing relevant. However, the patient does not co-orient to closing and carries on talking until he responds to the doctor's physical standing position. The doctor's instruction giving may not be hearable as a management proposal since the instruction to see another doctor and request a new drug is not such a tangible form of problem management as, for example, producing a prescription for that drug. In extract 9 the patient does not verbally align with the doctor's move into closing until he has completed an account for his weight gain and not knowing about his diabetes. As seen throughout this thesis, the patient constructs his condition as a moral concern by attempting to show that he is not entirely responsible for it. Extract 9 demonstrates that patients may use closing sequences as a space in which to perform moral work. Even when institutional tasks such as treatment discussions and form handovers have been completed, patients may orient to the moral business of establishing adequate patienthood as ongoing. This may particularly occur when the patient's moral status has been challenged elsewhere in the consultation (see the doctor and Rupert's treatment discussion in chapter 7 that precedes extract 9). This extract suggests two points of relevance for healthcare practice. It suggests that additional medical concerns are not the only basis for a patient 'door handle' remark and demonstrates that patients orient to the importance of moral work throughout the consultation.

Throughout this chapter I have observed the importance of non-vocal actions in the accomplishment of closing. As observed by Heath, patients often combine a verbal orientation to closing with a physical body shift that suggests they are preparing to leave the room. Furthermore, the doctor's non-vocal actions can enhance the closing sense of his talk. These actions include beginning to stand (extract 5), offering a handshake (extract 4) or shifting body position (extract 6) during his own talk or the patient's in a way that strongly suggests the relevance of closing. Patients appear to monitor the doctor's non-vocal (as well as verbal) actions when aligning with a move into closing. This builds on CA knowledge of non-vocal actions in medical encounters. The frequency of these non-vocal actions may be another reason why closings tended to occur with relative efficiency. In extracts 8 and 9 non-vocal activities initiated closing themselves. In extract 8 after a possible management proposal from the doctor has not been treated by the patient as initiating closing, the doctor stands and looks at the patient without speaking. His physical stance is commented on then reciprocated by the patient. In extract 9, the doctor stands and walks over to the door whilst the patient produces his account and the patient ultimately reciprocates the orientation to closing. Both cases occur after possible verbal close orientations have not been reciprocated by the patient, so there appears to be a preference for initiating closing (partially) verbally before doing so with non-vocal actions alone.

The doctor's success in initiating closing with non-vocal actions when verbal ones had not been successful, indicates the constraining quality of physical movement. Standing up in a closing relevant environment not only conveys the oncoming close of the consultation, it also strongly prefers reciprocation. Similarly, a patient not stretching out a

hand to meet the doctor's may cause considerable interactional difficultly, perhaps more so than not aligning with a verbal proposal to close. Non-vocal actions therefore provide a useful resource to initiate closing when one participant continues to orient to the 'business' of the consultation rather than its end. Nevertheless, they are not completely constraining. In extract 5 the patient reciprocates a non-vocal orientation to closing whilst maintaining a verbal orientation to the consultation. In extract 9 the patient does not immediately follow the doctor in standing up. He also does not move towards the door when the doctor does. In this way he creates an interactional space to produce his account whilst the doctor is orienting to closing. So whilst non-vocal actions can be employed by the doctor to enhance/replace verbal moves into closing, they can also be used by patients as a resource to pursue their own particular agendas.

These findings offer a range of insights relevant to CA understanding of closings in medical encounters. In particular they indicate that secondary care consultations for chronic conditions, particularly where other institutional constraints exist, may involve a wider range of close initiating devices than primary care ones. They also indicate the importance of standing, shaking hands etc in the accomplishment of these sequences and therefore reveal the importance of capturing non-vocal actions for the conduct of conversation analytic work.

Thesis Discussion

In this thesis I have established the need for an interactional approach towards the study of obesity-related medicine, articulated a suitable methodology for this study and presented a series of analytic findings based on relevant fieldwork. In this final discussion chapter, I summarise the conclusions arising from the thesis and assess their contribution to CA, sociology and healthcare practice and policy. I then highlight opportunities for further research to build on these conclusions.

Summary of findings

The literature review chapters at the start of the study demonstrated the need for research into talk during medical consultations about obesity and suggested that certain normative issues may be relevant to these interactions. In my review of the medical, scientific, government and interest group literatures (chapter 1), I discussed alternative claims to construct obesity as a 'medical', 'moral' and 'political' problem. I showed that whilst these models appear to compete with each other, at times they also intertwine. The medical construction of obese individuals as 'victims' of ill health sometimes shifts to a moral one, where these individuals are transformed into 'villains' who have caused their own condition through the undesirable, undisciplined behaviours of overeating and under-exercising. Furthermore, medical solutions of diet, exercise, pharmaceuticals and surgery share the moral prescription that the obese patient accepts some responsibility for his/her own condition and makes a personal effort to overcome it.

The UK government treats obesity as a health problem and puts forward strategies to deal with it. The positioning of obesity as a (medical) policy issue is an example of how this constructed condition has 'actual' implications for social life. Here there are specific implications for healthcare practitioners and their patients in terms of how they identify, manage and discuss the condition in a healthcare setting. These implications are open to sociological investigation. This highlights that studies recognising the constructed status of obesity can still be concerned with practice.

The apparent intertwining of medical and moral issues in obesity policy suggests a number of issues of practice which may be of particular interest to analysis. Although the policy is placed under the remit of the Department of Health, the government nevertheless treats obesity as, in part, an individual responsibility, requiring people to manage their weight, be prepared to change their lifestyle behaviours and demonstrate their commitment to making an effort in order to 'earn' medical care. This requirement to demonstrate commitment is one of a number of ways in which policy places talk between the practitioner and patient at the centre of medical care for obesity. Since most interventions are carried out away from the encounter, talk is the central means through which consultations are conducted. This includes evaluation of progress, provision of advice and the praising of patients apparently necessary to encourage them in their weight loss efforts.

Despite its key role in the modern obesity 'crisis', interactions in medical treatments for the condition remain under-explored. In chapter 2, my review of the social scientific literature showed that most existing studies of obesity have attempted to explore the social dynamics

behind its prevalence or the way it is 'understood' in society. These suggest that individuals may regard their bodies in ways that challenge medical conceptualisations of obesity and invoke normative concerns in line with 'moral model' issues of responsibility and blame. However, these studies do not involve the direct observation of consultations about obesity, so cannot comment on how, or if, these differences influence medical treatment. My discussion of key sociological studies of food, the body and medical interactions indicated the benefits of focusing on talk. These studies describe talk as a collaborative achievement, during which moral concerns about eating, the body etc may become evident. They also indicate that, despite changes in social actor, interactions during medical consultations often proceed in a similar way: impersonal, bureaucratic and overtly neutral. This neutrality might be breached when talk refers to the kind of lifestyle issues not normally the subject matter of medicine. Since obesity itself is frequently labelled a lifestyle issue, these findings are directly relevant to my study.

The methodology and methods chapters (3 and 4) built on the insights of the literature reviews. Having demonstrated the benefits of an interactional approach, I established conversation analysis as the appropriate means to conduct my own research into talk during obesity-related medicine. I described how CA analyses talk as social action, through which certain events, such as medical consultations, are achieved. I then described how I designed and conducted my fieldwork in keeping with CA principles. My video recordings provided direct, reliable data on actual medical interactions and CA's transcription and analytic procedures produced detailed, empirical description of how they were achieved. This enabled systematic

analysis of the under-explored topic of medical interactions about obesity.

Each of the four data chapters focused on a specific interactional task or phase of the medical encounter. In addition to describing how these tasks/phases were accomplished, my analysis sought to identify how the interactional patterns observed might be connected to the particulars of the setting. In chapter 5, I showed how the doctor's opening questions are fitted to initiate routine consultations and are treated as such by patients. In their responses, patients produced assessments and/or information reports relevant to the consultation and marked the encounter as one in a series of meetings. Whilst doing so, they simultaneously accounted for their treatment behaviours, presenting themselves as knowledgeable about their condition, responsible for their implied successes but not responsible for any lack of success. They defended their right to be seen as legitimately 'ill' and receive continued medical attention. This moral work was jointly accomplished by patient talk and the non-constraining form of the doctor's turns, which enabled patients to present their news in their own terms.

In chapter 6, I collected examples of doctor turns that explicitly credited the patient for some 'good'. I found that the wording of these turns often differed from 'formulaic' or 'obvious' compliments identified in other (CA and non-CA) studies and that they frequently performed institutional tasks connected to the setting. For example, they could open or close a sequence of talk and function as a disagreement or account for a suggestion. They were often marked as conveying as assessment based on limited, subjective knowledge, through terms

such as "I think" and "you look". In response patients often minimised self-praise, by not producing upgraded agreements for example, in keeping with preferred compliment receipts. They also attended to the additional functions of the crediting turn. Furthermore, they asserted their rights to express knowledge about their own condition through agreements, reformulations and further talk on the topic. Expressions of patient knowledge were also observed in chapter 5 and occurred consistently in patient talk throughout the consultation. It therefore appears to be a central part of the 'work' patients perform in this setting. I noted a great deal of complexity in the interactions I was analysing and experienced considerable difficulty identifying compliment turns. I argued that current NICE guidance, which advocates the praising of obese patients, needs to recognise this complexity, and that it would be beneficial for CA to focus more on the identification of first turns.

In chapter 7, I observed the use of a particular interactional device at the start of the treatment/advice-giving phase of the consultation. I analysed two cases in which the doctor initiated the phase by asking the patient for his/her opinion on treatment change before delivering his own. This device has similarities with perspective display sequences observed in ordinary talk and in other stages of healthcare interactions, in particular diagnosis-giving. Soliciting another's opinion before producing one's own provides a subtle means to promote alignment between interactants. However, in medical consultations practitioner opinion-giving (plus advice, recommendations etc) about treatment is an expected task of the encounter. If the practitioner's opinion does not align with the patient's previously expressed one, this can cause difficulties for further talk in the phase. In my analysis I found that

when the doctor agreed with the patient's view on treatment, this enhanced alignment between them and established a positive environment for further discussion, including advice-giving. It also credited the patient with accurate knowledge about his/her health condition and treatment status. By contrast, when the doctor disagreed with the patient his subsequent moves to 'convert' the patient's treatment proposal towards his medically expert view involved talk that could be seen to challenge the patient's medical awareness and even his/her moral legitimacy. Therefore, in discussions about treatment, these opinion solicitations can increase both alignment and disagreement.

In the final data chapter, I observed the various ways in which closings were initiated in the consultation. I identified a range of actions that initiated a move into closings, including those observed in existing medical CA studies. I also observed practices previously found only in ordinary talk: namely, summary assessments and figurative expressions/truisms. I also found a number of cases in which the patient rather than the doctor initiated a move into closing. I connected the particular close initiating actions observed in my data to the setting in which they occurred. Future references could be seen to invoke the long-term, chronic status of the patient's condition as well the continuing treatment the patient would receive across a variety of settings. Where the patient's future was uncertain, a future referencing solicitation or expression mirrored this uncertainty whilst also suggesting the relevance of closing. Furthermore, the two cases of 'trouble' analysed in the data can be connected to features of the setting: the absence of a prescription preventing the delivery of a hearable management proposal and the patient's continuing orientation

to conducting moral work regarding his condition. I also noted the key role of non-vocal actions during these sequences in enhancing or even replacing the closing quality of talk. I suggested that the use of these non-vocal actions – such as handshakes and standing up – may be one reason why the consultations in my data finished with relative interactional efficiency, despite the institutional constraints imposed on the clinics.

At the outset of this thesis I stated that my study has relevance to conversation analysis, sociology and healthcare practice and policy. Through my analysis I have produced innovative findings that build on and add to knowledge in all three areas.

Contribution to conversation analysis

The primary aim of this thesis is to make a contribution to conversation analysis. The analysis in this study was prompted by an interest in how research into talk during obesity-related medical consultations can add to knowledge about the practices and norms of the interaction order. The most significant contribution my analysis makes to this knowledge concerns the conduct of talk in institutional settings, specifically in specialist, secondary care medical consultations for chronic conditions. As I noted in the methodology chapter, institutional CA does not assume that a medical, legal, educational etc setting dictates the form of talk that occurs within it, or that interaction will follow some special logic unique to the context and distinct from ordinary talk. Instead, analysis assumes the primacy of ordinary talk, maintaining that the turn-taking system observed there is the foundation on which interaction in all settings is based. Institutional CA considers how these

turn-taking norms are employed in particular ways which construct context. This includes the achievement of institutional tasks and the construction of interactants' context-relevant identities.

Throughout this thesis, I have also observed that most existing CA studies of medical interactions concern primary care consultations in which patients present a new health concern. The absence of studies concerning secondary care encounters, particularly those involving long-term health problems, is a significant research gap since the tasks and identities in these settings may differ from primary care ones in a number of ways. Whilst many consultations in primary care involve the presentation of a new problem for diagnosis and general discussion, secondary care consultations often involve detailed discussion of established health conditions that are already known to the practitioner and patient before the encounter begins. In addition, where consultations, either in primary or secondary care, concern chronic, long term conditions (such as obesity) which are unlikely to be 'cured' or even managed in a short period of time, the aim of the encounter is to monitor the problem rather than resolve it in the short-term. Furthermore, individual consultations for these conditions may not necessarily involve treatment changes or any new problems to discuss. My analysis makes a unique contribution to CA by showing how the talk produced by interactants shapes and reflects the particular tasks and identities associated with secondary level care for the chronic condition of obesity.

Firstly, my analysis of opening questions and responses showed that the delivery of the doctor's opening questions is fitted to the institutional task of routine consultations: to solicit information about

the patents' progress between appointments, as opposed to soliciting information about a new concern. Patients orient to this task by providing relevant information and so co-accomplish the start of the routine consultation. Furthermore, the moral work performed by patients in their opening responses (plus the doctor's turns which enable it) is fitted to their particular identities as long-term patients receiving continuing medical treatment for a chronic health problem. Patients in the WMC and DOC have already been given a diagnosis and receive routine appointments so, unlike patients in typical primary care consultations, they do not need to defend their decision to seek medical treatment. However, they do risk being discharged from either clinic if they are seen as unlikely, or not able, to make medical progress. By emphasising their efforts to get well and their personal role in achieving treatment successes, patients construct themselves as willing and able to make progress and therefore deserving of continued medical attention.

My analysis in chapter 7 connected the solicitation of patient opinion about treatment to particular context-relevant activities in the fieldwork clinics. Previous medical CA studies have noted the use of succinct perspective-display sequences to solicit patient/parental views before diagnosis-giving or to project the relevance of particular advice. My analysis showed how more lengthy sequences were employed to accomplish a different kind of activity: to solicit and discuss the patient's opinion on treatment. The doctor's "where do you think we should go from here?" type question, performed an explicit start to the treatment/advice-giving phase and treated the patient as competent to assess his/her own treatment needs (whilst subtly conveying that change was necessary). Its use at the start of the phase simultaneously

acknowledges and constructs the consultation as involving a condition which requires active patient participation. Furthermore, the doctor's orientation to delivering his own opinion, even where it disagrees with the patient, demonstrates a focus on his institutional task of providing expert treatment advice. Talk following disagreement functions to attempt to 'convert' the patient's expressed treatment views towards a more expert, medical position. It may therefore involve appeals to medical authority and talk that appears to question the patient's knowledge.

Finally, my analysis of closing sequences suggested that the task of ending consultations about chronic conditions might involve the use of a wider range of interactional devices than observed in new problem encounters. Since treatments for chronic conditions can rarely, if ever, be labelled as satisfactorily complete, it can be difficult for the practitioner to produce a hearable management proposal that suggests the conclusion of medical business. Therefore a wide range of future references, including ones which invoke a non-specific future, may be employed, along with other devices such as summary assessments and figurative expressions/trusims that have been observed previously in mundane settings, but not medical ones. Additionally, institutional constraints such as the absence of prescription-giving in the fieldwork clinics may connect to difficulties in closings. Finally, my analysis also revealed that non-vocal actions played a key role in these sequences. This adds to CA understanding of how participants monitor each others' verbal and non-vocal behaviours to accomplish certain (institutional) activities. Furthermore, non-vocal actions can counter the difficulties in closing that may occur when other participants remain oriented to the business of the consultation as ongoing.

A central theme running throughout the data analysis is the constant and consistent delivery of patient 'accounts'. At various stages of the consultation, patients produce turns that represent themselves as knowledgeable about their condition, making a continued effort to become well, responsible for treatment successes but not responsible for any setbacks. These accounts, and the moral work performed in them, can be connected to particular tasks of the consultation. For example, as opening question responses they justify the patient's right to receive continued medical attention and provide a pre-emptive defence against any censure that may follow later in the meeting. In addition, they can be seen to justify their identity as legitimate patients. By constantly attributing weight gain to unwanted factors – overeating as caused by drugs making the patient feel hungry, lack of exercise as a result of injury not personal choice – patients orient to the possibility that if they did not produce these defences, their health status could be seen as their own fault. By repeatedly referring to their treatment efforts they invoke the idea that it is not (morally) enough for them to be seen as sick; in order to be legitimate patients they need to be seen to be doing something about it. In constructing themselves as knowledgeable, compliant, responsible and committed they simultaneously construct the identity of a 'good' patient as someone who has all these qualities.

These features have been noted in existing medical CA studies about various health conditions. My thesis shows how they take particular forms in secondary care consultations that orient to the continuing (rather than temporary) status of the chronically ill patient. In addition, I argue that their frequent use in these data function to construct obesity as a moral concern in addition to a medical one. Alongside

gaining weight in the first place, failing to carry out the behavioural changes necessary for treatment progress can be seen as evidence of non-compliance, non-commitment and irresponsibility – unless defended as otherwise. By constantly invoking these normative issues in their talk, patients construct their moral identity as a highly charged one. This is shown in the frequency with which patients produce moral work across various phases of the consultation. It is also shown in the way it is produced whilst patients perform other, possibly contradictory actions. In chapter 5, I described how one patient designed her response to the doctor's "you're looking very well" to provide medical information relevant to the start of the consultation and to avoid self-praise following a possible compliment whilst also working to enhance her agency in relation to the treatment success assumed by the doctor's turn. Furthermore, the presence of patient accounts during closing sequences, even whilst patients are co-attending (non-vocally) to closing, suggests the importance of this moral work. The medical tasks of the consultations may have been completed but patients still sometimes treat the need to establish their legitimate status as ongoing.

A corresponding issue is that the doctor frequently produces turns that enable this moral work to be produced. This was seen particularly in the chapter on opening questions, but throughout the analysis I have shown that the doctor tends to respond to patient accounts for weight gain etc with continuers that do not challenge the patient's talk and encourage it to go on. In this way, the doctor constructs his institutional identity as overtly neutral. I have also shown that this constructed neutrality may at times be breached. In chapter 7, I observed how the doctor's disagreement with the patient's treatment

proposal involved implications that that he may not be able to carry out his proposed necessary lifestyle changes. These inferences incorporated details from the patient's earlier talk and the doctor's sceptical stance marked a contrast between the patient's view and his own expert position. In moving away from his neutral position, the doctor could be seen to question the patient's medical and moral status. These findings build on conversation analytic understanding of the normative concerns inherent *to* talk and invoked *by* talk.

Finally, my analysis contributes to methodological issues within CA by demonstrating the benefits of using video for data collection. I have shown that non-vocal/visible actions such as body movement and gaze are often central to understanding the way talk proceeds in these encounters. Having video recordings therefore provides a very strong analytic advantage.

My analysis has also shown that CA can offer a number of insights to sociology (see below) and I suggest that this relationship can be reciprocal. For example, on various occasions in the data, the doctor and patient produced talk that invoked issues relevant to certain sociological concepts, such as the sick role and the moral model of obesity. It is possible to recognise these concepts as typifications but simultaneously use them to consider what is occurring within the interaction. In addition, I have argued that CA can benefit from insights provided by other forms of linguistic analysis. In my chapter on compliments I detailed my unresolved difficulties in applying CA to define a complimenting first turn. I argued that despite CA's epistemologically justified emphasis on responding turns, it is also necessary to analyse the form of the initiating first turns themselves. A

task for further analysis is to identify recurrent features that exist in compliments, assessments etc, and thereby enabling identification of these actions even when they are not treated as such by the recipient. This will benefit the identification of these turns when they take non 'obvious' forms or occur in institutional settings. Insights from non-CA fields, such as speech act theory, may provide one starting point for this work.

Contribution to sociology

My analysis also offers a significant contribution to sociology. It provides a series of novel findings relevant to sociology about obesity whilst building on existing arguments in the sociology of medical interactions. In chapter 2, I characterised existing sociological work on obesity as split by an in/of distinction. Sociology 'in' obesity analyses its existence in society with reliance on methodologically flawed statistics and definitions. Sociology 'of' obesity analyses its construction in society and frequently criticises the dominant discourses which position it as an urgent, medical problem. In each case, the topic of medical treatment for obesity has been neglected. My analysis therefore makes an immediate contribution by helping to fill this research gap. In addition it provides a methodological contribution that overcomes the in/of distinction. By focusing on how obesity is talked about, rather than what it is, my analysis recognises the constructed status of the condition but acknowledges that this construction has actual consequences (other than abstract discourses) that can be studied empirically.

In addition to its methodological advantages, this interactional approach contributes to the sociological understanding of obesity. I have shown that the moral issues claimed to be prevalent in modern discourses and understandings of obesity can be observed in medical consultations about the condition. Normative concerns about individual effort and responsibility for weight management are often invoked and patients do sometimes talk in ways that reject the moral modelling of obesity, for example when implying that they are not personally responsible for weight gain. Crucially, my analysis shows that these moral issues are contingent on talk. They are not automatically 'there' before the consultation begins and it is not inevitable that they will arise. Instead, they appear through collaborative interaction between doctors and patients. That they appear so frequently and consistently take the same form, suggests that moral understandings of obesity are prevalent and powerful. It also suggests that they intertwine with the demands of patienthood (see below).

In addition to opening up new areas of sociological investigation into obesity, my analysis also adds to findings relevant to the sociology of medical interactions. As I have discussed at several points in the thesis, CA studies have contributed a great deal to this field. In particular they have done much to question assumptions about structural medical dominance and the practitioner's ability to control the conduct and outcome of consultations. Interactional asymmetries can be observed within the consultations but they can frequently be explained with reference to turn-taking norms without requiring reference to external factors such as the structural power of medicine. For example, in chapter 7 I described a lengthy sequence of talk during which the doctor asks a series of questions about the patient's home life and

appears to challenge his responses to them as medically unsatisfactory. This can be seen as a kind of 'intrusive' medicine that covers non-medical topics and treats the patient as (morally) accountable for his/her actions. I showed that this sequence of talk was organised by the doctor's initial solicitation of the patient's perspective. The doctor was delaying (whilst hinting at) his own disagreeing opinion and attempting to shift the patient's displayed perspective away from an assertion that all he needed to do was 'up' his exercise. The doctor's (intrusive) questions about the patient's 'lifeworld' were based on information the patient had already introduced to support his assertions and defend his status. In addition, the doctor's disagreements took the preferred form: delayed and mitigated rather than overt and strong. Whilst the sustained interactional environment of non-alignment can provide a hearing of the talk in this discussion as unusually 'tense' and the patient may have experienced it as negative and harsh, it does not provide evidence of the structural dominance of the practitioner or the surveillance power of medicine. Instead, its unfolding can be explained with reference to established turn-taking practices.

In a similar way, reference to the norms of the interaction order rejects as simplistic sociological concepts of the active practitioner and passive patient. In the fieldwork consultations the doctor performs the majority of initiating actions and so his talk accomplishes the start and completion of most phases. However, patients do make use of opportunities to be interactionally 'active'. For example, they use the opportunity to provide extended talk during opening question responses to perform a considerable amount of work: co-accomplishing the start of the consultation, setting a framework for the encounter, defending their rights to attend the consultation and defending their

status as patients in general. They also use responses to crediting turns as opportunities to assert their knowledge about their own condition, displaying that their awareness of their progress precedes doctor comments about it. They also sometimes initiate the close of the consultation. Additionally, where patients have the opportunity to perform initiating actions they may use them to strong effect. In the same 'intrusive' extract mentioned above, the patient used his opinion display, an initiating first assessment, as an opportunity to name explicitly a treatment action he did not want to pursue (medication). As a form of resistance, this interactional move was very difficult for the doctor to reverse, not least due to the preference against overt disagreement. Ultimately, the patient's view prevailed and the consultation closed with an agreement that continued treatment would take the form of exercise, not medication.

Whilst revealing the overly simplistic form of one area of medical sociological thought, my thesis also suggests the enduring relevance of another. When discussing the medical constructions of obesity (chapter 1), I noted that the solutions put forward to solve the 'problem' frequently invoke the behaviours, privileges and obligations of the 'sick role'. Obese individuals are required to recognise they have a health problem, seek expert help about it, want to get better and make an effort to get better. In return, they receive the benefit of having their illness labelled as 'legitimate' and of exemption from certain social obligations. Even within the medical literature, tensions arise. Some claims-makers suggest that when individuals cause the onset of their condition through voluntary, 'unhealthy' behaviours, they reduce the extent to which they are automatically entitled to medical care once the consequences of those behaviours become disagreeable. They may be

denied help for their weight and be required to resolve their weight problem before they can receive treatment for any associated conditions. Within the sick role, not being held responsible for one's condition is a privilege of legitimate illness; these literatures suggest that this privilege may be denied to those with 'lifestyle' conditions. In chapter 5, I connected the patient accounts produced in response to opening questions (and throughout the consultation) to the same sick role requirements. All patients show that they are knowledgeable about their condition, are ready to comply with expert advice and are prepared to make an effort to get well. They also orient to the same tensions around responsibility noted in the literature. In their talk, patients consistently enhance their agency in relation to implied treatment successes. They offset the problem of being seen as responsible for their initial condition by indicating that their efforts have led to health improvements creditable to themselves. By contrast, patients work to avoid being held responsible for any implied lack of success. The reporting of mitigating factors in relation to weight gain, lack of exercise etc functions to separate patients from (moral) blame for the worsening of their condition. In this way patients can be seen to use their talk to demonstrate that they are making an effort to exit the sick role and to justify any lack of success in exiting it. Parsons' work on the sick role has received much criticism within sociology for its apparent limitations (see Parsons, 1975), including its inability to explain long-term conditions and those caused by lifestyle behaviours. However, I argue that rather than struggling to explain all forms of illness in one ideal type, Parsons in fact shows us why individuals with chronic and/or lifestyle conditions sometimes struggle to be seen as legitimately ill. In sociological terms, illness is not 'just' about the biological condition; it is about gaining normative sanction for deviance

from social norms. Individuals with long-term, 'incurable' problems or problems caused by their own behaviours, may experience greater difficulty in receiving that sanction. This is shown in the defensive nature of their talk.

Contribution to healthcare policy and practice

The third area my research contributes to is that of healthcare policy and practice. Once again, this contribution is methodological as well as topic-based. The use of CA provides empirical, naturalistic data on what occurs during medical consultations about obesity. It enables detailed description of interactions – a key concern in current medical guidelines – rather than relying on reports of interactions generated through interviews, surveys etc. These empirical descriptions provide evidence of how medical communication unfolds. Where analysis identifies problems that occur in the interaction, policy makers and healthcare practitioners might select to consider whether these problems should be addressed and how they might be overcome. This is not to suggest that CA itself should prescribe what makes 'good' communication in a healthcare setting; instead it indicates that CA's descriptive, empirical findings can provide the information necessary for practitioners and policy makers to assess this communication in terms relevant to the tasks and goals of the setting.

My research makes two particular topic-based contributions in this area. Firstly, it demonstrates the constant and consistent ways in which patients invoke normative issues in their talk. These normative issues invoke the simultaneously moral and medical status of obesity as well as the overall responsibilities of patienthood. Patients can be expected

to defend their moral status in consultations about any kind of medical problem, but these defences may have particular resonance when the consultation involves obesity since its connection to lifestyle behaviours can infer individual failings. The prevalence of these normative issues in obesity-related consultations provides several points of consideration for practitioners. Practitioners could choose to recognise this moral talk as a feature in consultations and be aware of the ways in which their own talk can affect its production. For example, opening question responses are a place in the consultation where patients may produce a lot of defensive, moral talk, as here they have the opportunity to talk at length about their health concerns. Practitioners can enable patients to produce this talk by asking generally worded opening questions which do not project a particular topic for the patient to talk about or make assumptions about his/her health status. My findings show that patients pursue opportunities to make these normative references across all stages of the consultation and that this can sometimes complicate the achievement of other tasks. For example, patients sometimes continue to defend their moral status after the practitioner has initiated the close of the consultation, thereby slowing down this process. Practitioners can therefore consider whether providing opportunities for patients to produce extended (moral) talk at the start of the consultation, and for this talk not to be challenged in response, could reduce the likelihood of these complications occurring later on, such as in closing sequences. In terms of obesity-related consultations in particular, practitioners can also recognise the normative difficulties patients may have in accepting responsibility for any lack of progress or inability to accomplish behavioural changes. This can lead to interactional difficulties when talk involves the discussion of treatment changes. Patients may reject the necessity for change and treat

practitioner assertions of lack of treatment success as a moral as well as medical challenge.

Secondly, by describing the complex range of activities occurring during talk in consultations, my analysis demonstrates the need for more sophisticated guidelines about medical communication. In my chapter on crediting turns, I cited the single sentence NICE guideline advocating that practitioners praise their obese patients. However, my data showed that in the medical context, hearing a turn as praise is extremely difficult. A positive turn may be a straightforward assessment of progress, not delivered to credit the patient directly, and may perform a variety of other actions related to the task of the encounter. If this difficulty exists for the analyst, it is also likely to exist for the patient and perhaps for the practitioner too. Problems of identification can imply problems of response. The production of an acceptance following a non-crediting turn could cause embarrassment, whilst a self-praise avoiding downgrade can undermine or be undermined by the patient's previous work to enhance his/her agency in relation to treatment success. Furthermore, designing a response to deal with the practitioner's praise, plus any other functions performed by the talk, can be a very interactionally complicated task. My data indicate that patients sometimes have difficulties responding to crediting turns and practitioners could consider what consequences adhering to the NICE recommendation to praise wherever possible might have for the (timely) progress of the consultation. This does not suggest that praising is not a worthwhile activity in the medical setting or that patients do not value it. However, it does show that the giving of praise involves more interactional consequences than a single sentence can convey.

In a similar way, my analysis of opinion displays shows how apparently straightforward, 'positive' interactional moves by the practitioner can have varying outcomes. The practice of soliciting the patient's views on how treatment should proceed can be seen as a practical example of patient-centred medicine. It treats the patient's opinion as relevant and the patient him/herself as knowledgeable enough to assess his/her own problem and progress. It is therefore particularly suited to consultations about long-term conditions such as obesity. Where the practitioner and patient are in agreement, this practice enhances the patient's status as competent. However, where the practitioner and patient disagree, this challenges that status and can cause interactional tensions. Practitioners could be encouraged to be aware of the 'double-edge' status of soliciting patients' views on treatment before they deliver their own and thereby be prepared for any interactional difficulties that emerge from it. They could also be encouraged to consider whether any previous talk in the consultation indicates that the use of this device will be more likely to result in agreement or disagreement. For example, previous talk from the patient may suggest that he/she is likely to reject the practitioner's own view of treatment change. The practitioner could then consider how to deal with this likely disagreement.

Opportunities for further research

As I have shown, my research makes useful contributions to the fields of conversation analysis, sociology and healthcare policy and practice. These contributions can be maximised through further research. During the course of this PhD I had to make a series of decisions over which of the many analytic themes emerging from my data I wanted to study.

These decisions inevitably resulted in a number of potentially fruitful topics not being pursued. Further research on these data would provide opportunities to examine them. In particular, I am interested in further conversation analytic study of the treatment/advice-giving phase. In addition to the opinion displays I analysed in chapter 7, this phase of the consultation frequently involved negotiations about treatment changes, patient orientations to the appropriateness of different interventions and lengthy doctor explanations of different treatment options. In keeping with existing CA data on patient 'resistance', treatment negotiations often resulted in more concessions being made by the doctor than by the patient, with the doctor typically invoking a 'deal' by which the patient could follow his/her preferred route as long as it proved successful within a certain timescale. I am interested in how these deals are projected and agreed upon, in particular in terms of how they invoke the obligations of the patient and doctor. Where disagreement over treatment occurred, this almost always took the form of the doctor preferring a pharmaceutical or surgical intervention and the patient preferring (to continue with) lifestyle change. Patients appear to orient to a hierarchy of treatment in which doing it 'by themselves' is preferable to having it done for them. I would like to analyse how this hierarchy is invoked in talk and how it relates to moral concerns about obesity and patienthood. Finally, when the doctor presented explanations about different interventions, e.g., presenting the option of a pharmaceutical treatment or surgery, he frequently constructed his talk as overtly neutral but it was often 'obvious' that one option was preferred over the other. I am interested in how this was done and what consequences it has for patient decision-making.

Another analytic issue I am interested in pursuing in my existing data occurs throughout the consultation. During analysis, I noted that patients sometimes refer to "my weight" and at other times to "the weight". Additionally, the doctor sometimes talks about what "we" do or are doing, but at others refers to what "you" do or are doing. It would be analytically useful to uncover whether or not these different references are systematic, in particular to identify what stages of the consultation they occur in and during the conduct of which types of task. This in turn would enable investigation of how they relate to the normative themes of responsibility, agency and effort already observed in the thesis.

Further investigation of my data would demonstrate the range of other interactional issues arising in specialist consultations about obesity. The next analytic step would be to conduct new fieldwork in a different, but associated setting. This would enable comparison and could take a variety of directions. For example, it would be useful to analyse other types of secondary care consultations and do more to overcome the absence of CA work in these medical settings. It would also be useful to research consultations about other kinds of chronic condition, to assess whether various issues arising here – such as patient defences of the right to receive continued medical care and complexities in achieving closing – can also be observed. I am particularly interested in continuing research into medical talk about obesity. The (now defunct) Weight Management Clinic and Diabetes and Obesity Clinic where I collected my data are two of a very small number of specialist obesity clinics existing in the UK. Patients are in fact more likely to receive treatment for their obesity under the management of their general practitioner or general practice nurse. More specialist support may take

the form of meetings with a dietician or consultations providing preparation/after-care in relation to surgery. This represents a wide range of settings in which treatment for obesity may be approached in a range of ways. Data collection in these other settings would enable a comparison of the interactions that occur within them. A useful task for analysis would be to identify which interactional practices are 'generic' to medical talk about obesity and which may be contingent on the specifics of the setting.

These findings would add to CA knowledge of medical talk and sociological work on obesity. They would also benefit healthcare policy and practice by raising awareness of interactional practices common to all healthcare consultations about obesity and the consequences they might have for the outcome of the encounter. In particular, analysis could identify difficulties that often arise in talk and practices through which they may be overcome. An ultimate goal of this direction of research would be the use of CA in the design and conduct of a randomised clinical trial. This kind of research would enable systematic investigation of how certain interactional devices influence treatment outcomes. For example, established CA-based findings could lead to the development of different advice-giving approaches which would then be delivered under trial conditions in different obesity-related healthcare encounters. The outcomes of these encounters could then be assessed using CA (alongside other methods) enabling healthcare providers to draw conclusions about what constitutes 'effective' clinical practice.

I have suggested a variety of ways in which the conversation analytic study of medical interactions about obesity can continue. These suggestions propose a considerable amount of, increasingly ambitious,

work. Nevertheless this work would ultimately prove beneficial. Obesity continues to be an issue of growing medical, moral and political concern across the globe. The increasing volume of communication about weight and weight loss includes an apparent rise in the number of individuals who talk about their own obesity in medical settings and use this talk to defend their status as legitimately and normatively 'ill'. Therefore, at the same time, the need grows for valid, interactional research to investigate how this talk is done.

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