"*What do you expect from physiotherapy?*"

A conversation analytic approach to goal setting in physiotherapy

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Abstract

Professional practice guidelines direct health care professionals to include patients in the decision-making process and to establish collaboration for therapeutic goal setting. Currently, little is known about the interaction between patients and professionals during this process. The aim of this study is to shed light on goal setting practices in physiotherapy.

Twenty-eight consenting patients seeking physiotherapy for their musculoskeletal problems and their therapists were videotaped during three consecutive sessions. Sequences related to goal setting were selected, and Conversation Analysis was chosen to analyse patient-therapist interactions.

The data comprise fifteen episodes in which therapists enquire explicitly about goals. Findings show that two assumptions underlie these enquiries: a) that patients have a goal in mind, and b) that they are able to articulate it. My data indicate that this is not straightforwardly the case in practice. Patients orient in their responses to epistemic dimensions related to issues of whether they have access to this knowledge, and whether they treat themselves as entitled to know about goals. When patients respond to therapists' enquiries, they use a variety of interactional resources to convey their epistemic orientation. I further found that therapists use different strategies for following-up patients' responses: these have different implications for patients' continued talk. My analysis also shows that a goal can only be treated as acceptable by therapists when it is amenable to improvement by physiotherapy.

My study indicates that the process of goal setting is not as straightforward as policy documents suggest. In actual practice it requires addressing and managing underlying assumptions and epistemic dimensions. A better comprehension of the interaction between physiotherapists and patients will contribute to better understand the limitations of current goal setting theory, and how and why current policies on goal setting may not have the desired effect.

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Chapter 1: Thesis introduction

"We must walk consciously only part way toward our goal and
then leap in the dark to our success."
Henry David Thoreau

My aim in this thesis is to investigate the interaction between patients and physiotherapists during goal setting in an ambulatory care setting. Goal setting is widely promoted in today's society: goals are set by sports people in preparation for events; applied as a tool for performance reviews in professional settings; and used as a way to encourage patient participation in health care. In this latter context, the World Health Organisation suggests using goal setting as a "strategy to encourage active rather than passive decision making" (Peri et al, 2006, p.1).

Over the past few decades, the notion of patient participation in health services has been linked with the patient's right to informed consent (ASSM/FMH, 2008) and to provision of information regarding treatment risks and options (FMH, 1996). Contemporary physiotherapy guidelines for good practice include recommendations to involve patients in decisions about their treatment (Physioswiss, 2006; WCPT, 2011).

Empirical evidence seems to suggest that patients and staff perceive a positive relationship between patient participation and goal setting. A synthesis of qualitative interview studies on patient participation found that goal setting was perceived by patients and staff as a key moment at which to give patients opportunities to participate actively in physiotherapy (Schoeb and Burge, 2012). Yet, there is limited evidence that goal setting has a positive effect on rehabilitation outcomes, or that it improves the patients' adherence to rehabilitation programmes (Levack, Taylor et al, 2006). Furthermore, it is argued that barriers to goal setting outnumber facilitators (Sugavanam et al, 2013). Currently, there is not sufficient evidence to suggest that goal setting is effective and that it accomplishes what its advocates propose.

Goal setting can be considered integral to the decision-making process in rehabilitation (Schulman-Green et al, 2006). Clinical decision-making includes the practice of how to come up with goals to plan and implement treatment interventions (Holliday et al, 2007). Yet, there are two opposing views with regard to this process. One view sees clinical decision-making as the intellectual process of clinicians seeking to arrive at a diagnosis or management plan for patients (Rothstein, Riddle, and Echternach, 2003; Childs and Cleland, 2006). The other understands clinical decision-making as a social phenomenon requiring interactional and linguistic skills (Loftus, 2006; Edwards, Jones, Higgs et al, 2004). This second view is the one that inspires this study aimed at investigating the process of goal setting in musculoskeletal physiotherapy.

The incontrovertibly interactive nature of rehabilitation has become more and more evident over recent years. In physiotherapy, Jensen et al (2000) argue that therapists' expertise is constructed through interaction: "… the conception of practice includes the role of practical knowledge learned through listening to patients (…) and through collaborating with and teaching patients and families to maximise function" (p. 41). This illustrates the collaborative and interactive nature of health care practice and indicates that the patient-professional interaction is at the core of physiotherapy practice.

Understanding the interaction between patients and health professionals, however, is not an easy task. It is not a coincidence that this thesis concerns the field of physiotherapy. I have been a practitioner for many years, specialising in manual therapy and in treating patients with musculoskeletal problems (e.g. low back pain, sprained ankle). During my time as a physiotherapist, I have asked myself questions regarding goal setting and the impact of patients' needs on professional practice. Our research group (Schoeb et al, 2005) received funding from the Swiss National Science Foundation to undertake a cohort study investigating the use of the goal setting tool GAS (Goal Attainment Scale). The objective was to compare two different communicative approaches: one traditional approach in which therapists set goals for their patients and

the other one using GAS to establish the goals collaboratively. The analysis of patients' outcomes with regard to function, quality of life and satisfaction with therapy services showed that there was no statistically significant difference between those two groups (Schoeb et al, 2010) even though, theoretically, there should have been an improvement for the group using GAS. So what exactly was going on in interactions between patients and physiotherapists that could explain the findings of our study?

Our own, and other evaluation studies employing tools such as GAS, generally use quantitative methods to investigate the effectiveness of the interventions (Turner-Stokes and Williams, 2010). This approach, however, has limitations: while it may be appropriate to use quantitative analysis to measure outcome, it is not useful for analysing the goal setting process. In order to investigate patient-professional interactions, a different methodological approach is needed.

When aiming to understand how patients and professionals engage with one other, video-recordings of actual interactions have many advantages. Having recordings allows for repeated viewing of sequences and enables detailed analysis of multiple aspects of patient–professional interaction (Barnes, 2005). Conversation analytic studies have also been shown to be effective in identifying patterns of communication and strategies used by patients and health professionals to manage the interaction and in generating understanding of the functioning of those patterns (Drew, Chatwin and Collins, 2001). In addition, Conversation Analysis contributes to understanding clinical practice from an interactional perspective and has been used successfully in training and education for healthcare professionals (Heritage and Robinson, 2011). There is a real benefit in pushing this form of interactional analysis into new spheres. This thesis does so by applying Conversation Analysis to investigate the patient-physiotherapist interaction during goal setting.

The findings contribute to the emerging view that goal setting is a less-than-straightforward process, and that there are interactional, clinical and organisational reasons for some of the difficulties that have been documented to occur when health

professionals try to set goals with patients (Wressle et al, 1999; Playford et al, 2000; Parry, 2004; Schulman-Green et al, 2006). While a cognitive conception of goal setting is omnipresent in the health care literature which emphasises psychological concepts relating to rehabilitation (Scobbie, Dixon and Wyke, 2011), there seems to be more and more reason to believe that sociological perspectives should be taken into consideration when conceptualising health care practice (Heritage, 2011; Heritage and Maynard, 2006b).

The text is organised in the following manner. Chapter 2 provides an overview of the literature on goal setting and clinical decision-making, critically reviewing concepts such as patient participation and patient-centred practice. In Chapter 3, I present in detail the methodology chosen to achieve the aim of this study, and further describe empirical aspects of the study. Chapters 4 to 6 are the analytic chapters. In Chapter 4, the analysis concentrates on therapists' practices for enquiring about goals and identifies assumptions that underlie these enquiries. Chapter 5 sheds light on patients' responses to therapists' explicit questions and explores what those responses convey about (un)certainty and agency. Chapter 6 focuses on how patients' initial responses are acknowledged and/or transformed in order to produce 'acceptable' physiotherapy goals. The final chapter discusses the findings chapters, considers further research avenues and draws conclusions about what those findings mean for sociology and Conversation Analysis, as well as for health care practice and education.

Chapter 2: Literature review

2.1. Introduction

This literature review sets the stage for this study. First, I present an overview of physiotherapy services and professional guidelines applicable to the therapists who were studied (Physioswiss, 2006). I start the literature review by illuminating some aspects of the professional-patient interaction, by reviewing current models of clinical decision-making and patient-centred practice, before focusing on the main topic of goal setting. In Section 2.3, I summarise theories of goal setting and current policies advocating those theories, then I present evidence about the practice of goal setting in rehabilitation settings. A discussion concludes this chapter.

The purpose of physiotherapy is to provide services to people to develop and maintain their ability to move and function throughout the lifespan (WCPT, 2012). Various skills are required for professional practice, namely professional, methodological, personal and social skills (Physioswiss, 2006). It is exactly those social skills which are under scrutiny here. In national and international policy documents, emphasis is put on social skills, that is on interactions between physiotherapists and patients (WCPT, 2011) and on the importance of a collaborative approach during the evaluation and treatment process (Physioswiss, 2006).

The process of evaluation and treatment in physiotherapy can be understood as comprising a series of phases (Physioswiss, 2006; see Figure 1 below): (1) **examination** including history taking and physical examination, (2) **analysis** and **diagnosis** which includes goal setting and treatment planning, (3) the determination of **interventions** and (4) **evaluation** of the intervention.

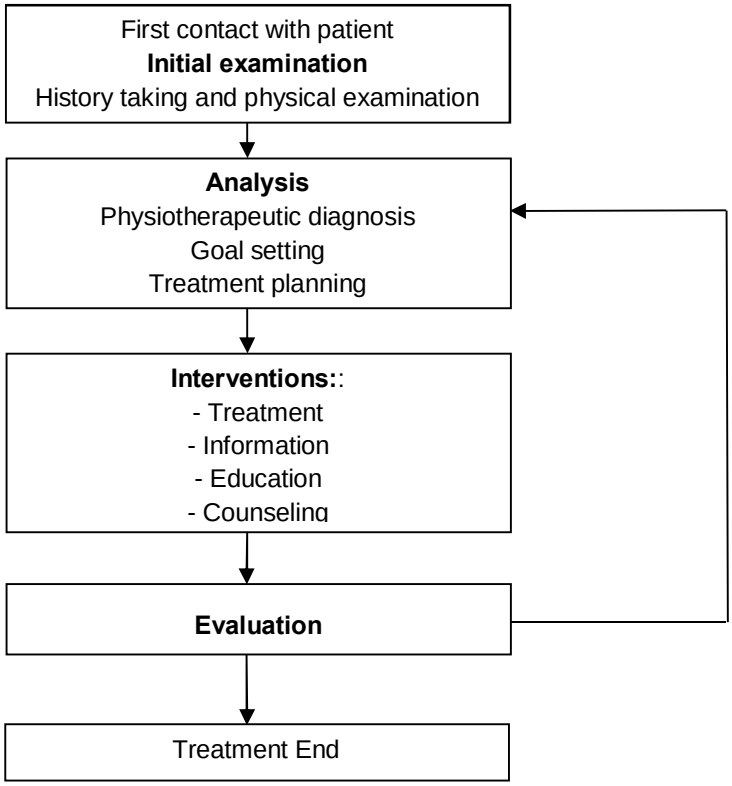


Figure 1: Physiotherapy evaluation and treatment process (adapted from Physioswiss, 2006, p.8)

It has been argued that the transition between examination (Phase 1) and intervention (Phase 3) are activities of clinical decision-making (Magistro, 1989) and as shown in this figure, includes goal setting (Phase 2).

The World Health Organisation (WHO, 2004) defines a goal as "a general or specific objective towards which to strive; an ultimate desired state towards which actions and resources are directed" (p. 27). Goal setting theories, developed in industrial North America in the 1950s and 1960s, posit that setting a goal influences human behaviour in such a way as to increase performance and motivation (Locke and Latham, 2005). While this cognitive approach to behaviour is predominant in the medical literature, goal setting has its foundation in policies meant to increase the public's participation in the community. The neo-liberal ideas of autonomy and self-determination have become increasingly important in Western democracies (Nordgren, 2010; McDonald et al, 2007). For example, UK policy documents emphasise that

community involvement is essential for improving services and achieving meaningful outcome for society (IDS, 2007) and that patients can make their own choices regarding their health (DoH, 2006).

To summarise, while individualism is fostered (self-determination, autonomy) emphasising patients' initiatives with regard to health-related issues, policy documents also emphasise the benefits of participation and community involvement. Underlying this seemingly contradictory movement lies the concept of shared responsibilities and collaboration. How this approach is carried over into the literature on patient-professional interaction is now the topic of the next section.

2.2. Patient-professional interaction

Patient-professional interaction is at the heart of any health care delivery, and the relationship between patients and health professionals has been the topic of many books and studies. In order to understand goal setting it is first important to understand the nature of the patient-professional interaction. A seminal study identified four core dimensions of expertise in physiotherapy: 1) knowledge that is multidimensional and patient-centred; 2) clinical reasoning and collaboration; 3) movement; and 4) virtues including caring and commitment (Jensen et al, 2000). Jensen and colleagues (2000) emphasise that "the conception of practice includes the role of practical knowledge learned through *listening to patients* and reflective practice, core beliefs about *patient-centered evaluation and treatment*, *collaborating* with and teaching patients and families to maximise function, skilful movement assessment through observation and manual skills, and *shared commitment of mutual respect and care*" (p. 41, emphasis added). The aspects noted above in italics show the collaborative and interactive nature of physiotherapy expertise. These aspects also show that patient-professional interaction is at the core of physiotherapy practice and that clinical decision-making happens interactively. The next section defines clinical decision-making as the basis of the model of patient-practitioner relationship.

2.2.1. Clinical decision-making

There are various definitions of clinical decision-making. Clinical decision-making is a term that is widely used in all health professions and is sometimes used as a synonym for terms such as 'clinical problem-solving' or 'clinical judgment' (Baker, 2001) or 'clinical reasoning' (Higgs and Jones, 1995). There are two opposing views of clinical decision-making. One view sees clinical decision-making as the intellectual process of clinicians seeking to arrive at a diagnosis or management plan for patients. The other view sees clinical decision making as a social phenomenon requiring social and linguistic skills (Loftus, 2006). This second view is the one that inspires this study's concern with the process of communication during goal setting in orthopaedic physiotherapy.

Research on clinical decision-making, or in this context clinical reasoning, originated in the medical profession and is based on models of cognitive science. The cognitive process of reasoning is defined as entailing hypothetico-deductive reasoning and pattern recognition (Edwards, 2000). Some physiotherapists have taken this road by establishing algorithms (Rothstein, Riddle, and Echternach, 2003; Schenkman, Deutsch, and Gill-Body, 2006) and clinical prediction rules (Childs and Cleland, 2006) aimed at improving decision-making. This approach reflects current trends in medicine and allied health professions and has also found its way into policy documents.

In the context of both the medical profession and the physiotherapy profession, decision-making is concerned with diagnostic decision-making. Yet, diagnosis in physiotherapy is still ill-defined, and there is as yet no widely accepted diagnostic classification (Miller Spoto and Collins, 2008). I will not further develop this cognitive perspective upon clinical reasoning here, but focus instead on a different understanding of this concept, which shifts the perspective from cognitition to interaction.

Clinical reasoning refers to the thinking and decision-making process used in clinical practice (Higgs and Jones, 2000). Different strategies of clinical reasoning were identified, amongst them 'interaction' and 'collaboration', which were used by therapists

as means to engage patients in exercises or discussions related to physiotherapy care (Edwards, 2000; Edwards, Jones, Carr et al, 2004).

In conclusion, interaction is key to clinical decision-making in professional practice. While most of the literature looks at clinical decision-making from a cognitive perspective, there seems to be a shift to a more interaction-oriented perspective. As my specific interest lies in the analysis of how decisions are constructed during goal setting, this interaction-oriented perspecitive will be the focus of this study.

After this introduction about the interactionoal aspect of clincal decision-making, the next section reviews the literature on models of decision-making. These models introduce the neo-liberal idea presented above, namely that patients have the right to participate in decisions about their care.

2.2.2. Models of patient-practitioner relationship

In medicine, decision-making has always been at the heart of the profession. The encounters between patients and their physicians receive scrutiny due to legal requirements of informed consent as well as an increased social awareness of patients' rights to self-determination. There are four models of treatment decision-making described in the medical literature: paternalistic decision-making, shared decision-making and informed decision-making (Charles, Gafni and Whelan, 1997, 1999) and interpretative decision-making (Wirtz, Cribb and Barber, 2006).

The traditional model is the paternalistic decision-making model in which the physician decides on treatments to implement. This model has long been challenged, and shared decision-making is the one being promoted currently in policy and practice. According to Charles et al (1999) shared decision-making comprises at least two participants (physician and patient) who take steps to participate in the process of treatment decision-making. Shared decision-making also includes information sharing as a pre-requisite and the elaboration of treatment decisions that have been agreed upon. In informed decision-making, the patient him/herself makes the decision after having received relevant information. Finally, in the interpretative model, the physician decides

on behalf of the patient by taking into consideration the patient's values and preferences.

All four models might be reflected in actual interactions, but priority is given to a normative approach, which focuses on integrating patients into decision-making (shared-decision making model). Further elaborations of the shared decision-making model has focused on integration of cultural aspects or different stages of disease (Charles et al, 2006; Montori, Gafni and Charles, 2006). Nevertheless, there remains inconsistency with regard to the definition of shared-decision making (Makoul and Clayman, 2006). Even though there is a recent development of evolving decision-making models (Entwistle and Watt, 2006), limitations due to dilemmas of professional ethics still remain (Wirtz et al., 2006). The limitations are related to questions of how patients should be involved and in which decisions they should be included. In addition, while many studies of shared decision-making have focused on identifying key concepts, far less emphasis has been put on investigating how shared decision-making really looks in practice. Furthermore, concepts such as shared decision-making might be, as some findings suggest, highly context dependent (Smith, Higgs and Ellis, 2007).

Although the shared decision-making model might be valuable from an ethical standpoint, as well as from the standpoint of potentially improving treatment outcomes, it is not clear how shared decision-making is achieved, and whether the principles of the concept fit the social organisation of the clinical encounter. The same can be said about another concept, patient-centred medicine, described in the literature as a prerequisite for effective interaction (Stewart et al, 1995). Patient-centred care has received wide acceptance in clinical practice across disciplines, including physiotherapy. I will now review this topic.

2.2.3. Patient-centred practice

While patient-centred care has been described since the 50s by Balint (Lewin et al, 2001), the current literature offers different definitions of 'patient-centred care', and reveals a lack of consensus on the definitions. One group of researchers defines it as

'sharing control' and 'focus on the whole person' (Lewin et al, 2001); other authors suggest five conceptual dimensions inherent to the concept: bio-psycho-social perspective, the patient as person, sharing of power and responsibility, therapeutic alliance, and the therapist as a person (Mead and Bower, 2000). It has also been argued that the dimensions of patient-centeredness are, firstly, the inclusion of the patient's perspective and, secondly, the stimulation of the patient to participate actively in the treatment (Michie, Miles and Weinmann, 2003).

One definition is omnipresent in the literature (Stewart et al, 1995) and is cited as the pillar of patient-centred care with six dimensions:

1) Exploring the disease as well as the illness experience
2) Understanding the whole person
3) Finding common ground regarding management
4) Incorporating prevention and health promotion
5) Enhancing the doctor-patient relationship
6) Being realistic about personal limitations and issues such as the availability of time and resources

Most of the literature concerns medical interactions, but the main characteristics of patient-centered care, such as respect and collaboration, can also be found in physiotherapy literature (CPO, 2009). Canadian physiotherapists are invited to practice 'collaborative client-centred practice' (p. 15), thereby promoting active participation of the client and enhancing their goals and values (CPO, 2009). When interviewed, physiotherapists have defined patient-centred care as an active process in which patients are engaged in order to reach collaboratively an agreement regarding goals (Sexton, Moore and Ramage, 2011). Furthermore, communication skills, context and professional experience are other additional factors faciliating patient involvement (Sexton et al, 2011).

One common theme found in the shared decision-making literature as well as in literature on patient-centred medicine is **patient participation**. Both concepts have the same underlying assumption: that participation of the patient in his or her care is a good thing. But Entwistle and Watts (2006) propose a different conceptual framework of patient involvement in shared decision-making. The authors criticise the previously described models as too narrow and propose to investigate **activities** related to decision-making:

1. Recognition and clarification of a problem
2. Identification of potential solutions
3. Appraisal of potential solutions
4. Selection of a course of action
5. Implementation of the chosen course of action
6. Evaluation of the solution adopted

The advantage of this proposition, according to Entwistle and Watts (2006) is that, in comparison to the previously reviewed models, investigating the activities of decision- making will help "patients to engage in a full range of decision-making activities" (p. 268). Therefore, it can be assumed that patient participation is a more complex concept than simply choosing from a list.

Patient participation has been subject to increasing investigation in the scientific literature. There are different perspectives on what patient participation means and how it should be investigated, depending on the assumptions underlying the study. I will come back to different methodological approaches for interaction analysis in Section 3.2. A book on qualitative perspectives on patient participation (Collins et al, 2007) questions some of the basic assumptions evident in the current literature. The authors' definition of patient participation is much more inclusive: "participation includes all forms of action or omission of action in which an interactant is involved" (p. 122). In this sense, you

could say that “you cannot not participate” (Peräkylä, Ruusuvuori and Lindfors, 2007; p.122). Peräkylä et al (2007) argue that there is no way that patients are not participating, even if there is silence; for example this silence might mark resistance to a course of action proposed by a doctor.

Furthermore, there is a line of argument that “patient participation in decision-making is justified on humane grounds alone and is in line with a patient’s right to self-determination” (Guadagnoli and Ward, 1998, p.337). Yet evidence suggests that not all patients desire to be involved (Thompson et al, 2007). Desire and capacity for participation depends on the illness type and seriousness of condition and on personal characteristics of the patient as well as the patient-professional interaction. Moreover, whereas there is consensus among researchers that optimal participation ought to match the patients’ preferences (Guadagnoli and Ward, 1998; Pierce and Hicks, 2001; Kiesler and Auerbach, 2006; Thompson, 2007), in practice patients often report that they do not play the role they have desired during consultations (Larsson et al, 1989; Gattellari et al, 2001; Ford et al, 2003; Ford et al, 2006; Hubbard et al, 2008).

Patient-centred practice has been promoted for years, yet only recently have researchers started to conceptualise it more specifically. Lawrence and Kinn (2011) reviewed the literature on patient-centred stroke care and found three broad themes pertaining to patient-centredness: meaningfulness and relevance of rehabilitation activities, quality, and communication. Within the first theme, goal setting, “the need to ascertain the priorities, concerns and goals of patients” (p. 319) was mentioned as one of the criteria.

Numerous qualitative studies (Young, Manmathan and Ward, 2008; Schulman-Green et al, 2006) focus on the perceptions of patients/caregivers and/or professionals regarding involvement in goal setting. In a study I conducted (Schoeb and Burge, 2012) we synthesized qualitative studies on patient participation in physiotherapy. Various activities were identified as moments in which patients were involved in physiotherapy: goal setting, information exchange, decision-making and exercise training. Yet, both

patients and physiotherapists find collaborative goal setting challenging for different reasons: communication skills of physiotherapists, lack of patients' knowledge about what is expected from them, physiotherapists' struggle to define concepts such as goal setting.

In summary, shared decision-making is advocated in the literature, even though it is unclear how patients should be involved, in which decisions they should be consulted, and in particular, how shared decision-making looks like in practice. While the cognitive model of clinical decision-making has been predominant, there is a shift towards an interaction-oriented perspective of clinical decision-making. Overall, it can be said that collaboration, participation and negotiation, as well as taking the patient's perspective into account are seen as the salient aspects of models such as shared decision-making and patient-centred care and are, therefore, related to the topic at hand: goal setting as an interactive achievement. While goal setting seems central to patient participation, it also is described as challenging. Let us now turn to the next section, which illustrates the current literature on goal setting.

2.3. Goal setting

Goal setting is at the centre of collaborative practice, of negotiation and of interaction in therapeutic encounters. As I have shown in the previous section, goal setting is considered important for making decisions regarding care. It is also closely related to the concept of patient-centred care that emphasises a close to equal partnership between patients and clinicians. In the next section, I propose that the approach to making those decisions derives from a cognitive model of behaviour, and I present an overview of current goal setting theories used in rehabilitation. Finally, I explore the application of these theories in policy documents and review the evidence about actual application of those theories in practice.

2.3.1. Goal setting theories

Goal setting theories were developed in the context of industrial North America in the 1950s and 1960s (Locke and Latham, 2005). While there are different theories,

they share one common thread: that goal setting has an influence on human behaviour and that it improves performance and increases motivation. Theories along this line, e.g. Self Determination Theory, Social Cognitive Theory, Goal Setting Theory and Health Action Process, have been adopted in recent years by health professions, and it has been suggested that goal-setting theories should be incorporated in clinical practice (Scobbie et al, 2009; Siegert and Taylor, 2004). These theories are rooted in the discipline of social psychology and incorporate a cognitive behaviorist paradigm (Siegert and Taylor, 2004). Below, I briefly review the main tenets of the theories most frequently discussed in the health care literature.

Self-determination model

Ryan and Deci (2001) developed a theory based on the idea that human beings, for whom intrinsic goals are a powerful motivator, are active, self-directed organisms with three fundamental needs:

a) Autonomy: individuals self-regulate and organize their experiences in order to function as unified and integrated human beings
b) Competence: human beings establish a sense of mastery of their environment by seeking and mastering challenges
c) Relatedness: individuals establish a sense of emotional connectedness to other human beings and would like to be loved and cared for

The fulfilment of those needs, according to Ryan and Deci (2001), is therefore a "natural aim of human life" (p. 147). They further stipulate that the feeling of competence, in particular as it relates to valued goals that were defined by the individuals themselves, is associated with subjective well-being. In other words, the self-determination theory posits that if individuals pursue the goals that they defined for themselves (ie. their intrinsic motivators) and strive towards mastery, this experience will contribute to their subjective well-being. The concept of mastery can also be found in Bandura's Social Cognitive Theory, which I explain below.

Social Cognitive Theory

Within his Social Cognitive Theory, Bandura (1977) introduced the concept of self-efficacy. The "perceived personal efficacy is the individual's belief in his or her own capability to organise and execute an action which is required for an expected outcome" (Bandura, 2007, p. 12). The expectation of personal efficacy will determine the effort put in the task as well as how long individuals are able to sustain the effort when faced with obstacles and difficulties. Evidence from controlled experimental and field studies seems to suggest that the belief in one's capabilities might have an influence on motivation and action (Bandura, 2009). Bandura's model emphasises that the perceived self-efficacy influences both motivation and performance attainments, either directly or through the impact of goals and outcome expectations. In other words, when those with low self-efficacy face obstacles, they might give up or only achieve mediocre solutions, while the ones who believe strongly in their own capabilities (high self-efficacy) will put in more effort to overcome the obstacles and, thereby, master the challenges. There are four main sources of information needed to instil self-efficacy (Bandura, 2009):

a) *Through mastery experience*: If individuals have always quick and easy successes, they expect this to happen all the time; however, usually the road to success is long and difficult, so individuals are required to deal with failures and setbacks.
b) *Social modelling*: Observing people pursue their goals and persevere raises the observers' beliefs in their own capabilities
c) *Social persuasion*: It is easier for individuals to believe in themselves if important people around them are confident with regard to their abilities
d) *Physical and emotional state:* Efficacy beliefs are influenced by anxiety and depression, but also by the perception of physical states.

In summary, perceived self-efficacy influences motivation and acts through goals. The higher individuals perceive their self-efficacy to be, the higher they set their targets and the more committed they are (Bandura, 2009). This development of the self-efficacy

theory - including goals explicitly as motivators - resembles the Goal Setting Theory, which I explain below.

Goal Setting Theory

Locke and Latham (2002, 2006) have been developing the goal setting theory over the last 40 years. The authors claim that there is a relationship between goal difficulty and task performance, that challenging and specific goals motivate performance. In addition, individuals need sufficient capabilities to perform the task, need to accept the assigned goals, need feedback on their progress, and all this must occur in a supportive environment (Locke et al, 1981). The main mechanisms by which goals are postulated to affect performance are:

a) directing attention
b) mobilizing effort
c) persistence and motivating strategy (Locke et al, 1981)

With regard to a cognitive approach to human behaviour, this goal setting theory is in line with theories previously mentioned in this section. While I have reviewed the most relevant theories for the topic of this study, there are several others which are sometimes mentioned in the context of goal setting (Siegert and Taylor, 2004; Scobbie, Wyke and Dixon, 2009): Emmons' subjective goals and well-being theory[1], Karniol and Ross' temporal influences on goal setting[2], Health Action Process Approach[3], Proactive

[1] Emmons' theory of subjective goals and well-being posits that the kind of personal strivings (what is important for an individual) has "a close relationship with the type of goals that matter to that person" (Siegert and Taylor, 2004).
[2] Karniol and Ross argue that "individuals are influenced by the past" (p. 6) and their representation of the future and that "the individuals' memory of the past can also play a vital role in determining the range and nature of the goals people will consider in the present (Siegert and Taylor, 2004; p. 7).
[3] Schwarzer's Health Action Process Approach suggests two phases: Phase 1 (goal intention) consists of a decision-making phase in which individuals develop goals, and Phase 2 occurs when plans are put in place to achieve those goals (action and coping planning) (Scobbie et al, 2009).

Coping Theory[4], and Self-regulatory Model of Illness Behaviour[5]. However, those theories are much less frequently used in the rehabilitation literature and not explicitly mentioned in policies and guidelines for clinical practice. Furthermore, those models not presented in detail here also share the underlying assumption of a cognitive-behaviourist approach to goal setting.

In sum, the reviewed theories advocated as useful for goal setting share similar assumptions. They posit that goal setting influences human behaviour in such a way that striving for a goal improves performance and increases motivation. This cognitive view of goal setting puts the individual's (i.e. the patient's) aspirations and wishes at the center of the action and does not take into consideration the co-participant. This approach might be problematic, and as I demonstrate later, can create interactional difficulties if those assumptions are not shared by both participants.

2.3.2. Policies of goal setting in rehabilitation

On a professional level, policy statements, including that by the World Confederation of Physical Therapy (WCPT, 2003), require professional physiotherapists to work in ways that involve making "decisions, setting goals and constructing specific plans to achieve these, taking into account relevant contextual factors" (p. 15). The most recent standards further indicate the collaborative nature of goals by stating that physiotherapists provide information ensuring that "treatment plans, goals and expected outcomes are agreed upon between the patient/client and the physical therapist and any changes in previously agreed intervention/treatment plans are discussed and agreed upon with the patient/client" (WCPT, 2011; p. 9).

[4] Proactive Coping Theory, developed by Aspinwall and Taylor (1997), posits that "people can anticipate and plan responses to threats likely to hinder goal achievement" (Scobbie et al, 2009, p. 327). There are some similiarities to the Health Action Process Approach (coping planning) and the Social Cognitive Theory of Self-efficacy.

[5] Leventhal proposes the Self-regulatory Model of Illness Behaviour with three constructs: illness representation and emotional reactions, coping response and appraisal (Scobbie et al, 2009; p. 327).

This approach has been adopted by most developed countries in the world and is promoted in Standards of Practice that professionals are obligated to adhere to (for the UK - CSP, 2012; for Australia - APC, 2006; for Switzerland - Physioswiss, 2006). The UK Standards of Physiotherapy Practice (CSP, 2012), for example, includes the following criteria

> 7.3.11 Members agree to common goals with the service user, multidisciplinary team and wider carers and family

Physiotherapists are required to negotiate goals not only with patients, but also with teams and family members, when appropriate. The Australian Physiotherapy Association (APC) includes goal setting as part of understanding the patient's health problem, including symptoms and their consequences, and notes the importance of being able to elicit the client's priorities, needs and goals. These standards are formulated as follows (APC, 2006, p. 36):

> 4.1.5: Goals, values and expectations of the client are identified
>
> This will include:
>
> – current and prior health status
>
> – symptoms and impairments
>
> – impairments and activity limitations and their influence on participation in self care, work and leisure activities
>
> – relevant health population information
>
> – workplace data collection
>
> – the client's priorities of concerns, needs and goals

In Switzerland, we find similar requirements for physiotherapists' professional competence. As described at the outset of this chapter, the process from the initial

greetings to the end of treatment goes through different phases. The Swiss Physiotherapy Association describes various skills required for professional practice, namely professional, methodological, personal and social skills (Physioswiss, 2006). In national and international policy documents emphasis is put on social skills, that is on interactions of physiotherapists with patients and their families or caregivers (WCPT, 2011) and the importance of a collaborative approach during the evaluation and treatment process (Physioswiss, 2006).

Professional conduct means adhering to professional regulations. Therefore, it is not surprising to find that one of the purposes of goal setting identified in published studies is to meet contractual, legislative or professional requirements (Levack, Dean, Siegert and McPherson, 2006). There are different approaches proposed in the literature to help achieve those requirements. One approach regularly advocated is the SMART (Specific, Measurable, Achievable, Realistic and Timed) approach to formulating goals (Bovend'Eerdt et al, 2009). This approach is intended to enable quantification of patients' performance and of the time in which the desired goal is achieved.

Yet, there are some indications that although goal setting is laid down in policy documents and standards of practice, it is challenging to implement in actual practice. Patients may not feel competent enough to actively engage in the process, and clinicians may be reluctant to actively engage patients in setting goals if they perceive patients might have limitations in communication and expertise (Rosewilliam et al, 2011). Evidence is mixed with regard to application of goal setting theories (Levack et al, 2011). This will be reviewed in the next section.

2.3.3. Evidence in clinical goal setting

2.3.3.1. Effectiveness of goal setting

One purpose of goal setting relates to outcomes: to either improve outcomes or to evaluate them (Levack, Dean et al, 2006). I will now review recent literature of both qualitative and quantitative studies that investigated the effectiveness of goal setting,

starting with the three recent literature reviews, followed by some studies on patients' and therapists' perceptions of goal setting.

Levack, Taylor et al (2006) reviewed evidence on the effectiveness of goal setting and concluded that "while some studies demonstrated positive effects associated with goal planning in local contexts, the best available empirical evidence regarding generalizable effectiveness of goal planning was inconsistent and compromised by methodological limitations"(p. 739).

Rosewilliam, Roskell and Pandyan's (2011) review focused on patients' and professionals' perception about the nature, the extent and the effects of goal setting in stroke rehabilitation. The authors found major discrepancies between patients' views and professionals' views with regard to the level of patient participation in goal setting. These discrepancies potentially lead to conflict, not just in the process of goal setting but also in the therapeutic relationship. The authors further identified challenges to goal-setting, some of which have been previously reported, such as limited time resources, standard documentation and professional routines. However, one challenge identified was related to the difference in expertise and knowledge between patients and therapists, which is of particular interest to my study. I will further explore those issues in Chapter 5. The review of Rosewilliam, Roskell and Pandyan (2011) concludes that there is only low-level evidence for patient-centred goal-setting practice, and that one should rather talk about 'clinician-centred', 'system-centred' or 'population-centred' goal-setting. They suggest future research that should unpack the complexity of goal-setting. This is exactly what this research will be able to do.

A more recent review examined both quantitative studies and qualitative studies (Sugavanam et al, 2013). The authors investigated the effects and experiences of goal setting in stroke rehabilitation by selecting 17 papers (seven quantitative and ten qualitative studies). The authors state that, while the methodological quality remained weak and the design differed between studies, goal setting still "appeared to improve recovery, performance and goal achievement, and positively influence patients'

perceptions of self-care ability and engagement in rehabilitation" (Sugavanam et al, 2013; p. 177). They also found that professionals and patients do not necessarily perceive goal setting in a similar way, as professionals rate themselves more collaborative than patients. The review also sheds light on the limitations of the evidence underpinning the goal setting theories, and that "barriers to goal setting outnumbered the facilitators" (Sugavanam et al, 2013; p. 177). While some of the barriers were more related to the population of stroke patients (cognitive and communication impairments), patients also raised the following issues: lack of understanding of the rehabilitation process, lack of motivation (e.g. depression), or lack of knowledge with regard to realistic outcomes. From the professional point of view, time and scheduling problems were seen as barriers, but also cultural differences, the difficulty of conveying the meaning of goals to patients, or doubts with regard to reliable tools for goal setting. All in all, the review challenges some of the assumptions underlying the belief in the benefits and the effectiveness of goal setting. In addition to the limited evidence, Suganavam et al (2013) insist on the importance of communication between therapists and patients during the goal setting activity: however, the authors give no further information about how they reach this conclusion.

Along the same line, Rosewilliam et al (2011) provided qualitative evidence that there was a discrepancy between professionals' medical and practice-based goals and patients' goals, which were oriented more towards relationships, home, leisure and function. The authors suggest that professionals set goals that are not entirely in line with patients' goals.

Those systematic reviews show that goal setting does not seem to be a straightforward activity in a way that it is suggested in policy documents. It is reported to be complex and the potential for disagreements regarding goals seems substantial (Bradley et al, 1999). The authors describe modifying factors that are related to the individuals: degree of risk-taking, perceived self-efficacy and acceptance of the disease. They also conclude that urgency and the irreversibility of the particular disease have an

influence on the goal-setting process. Lastly, but importantly, the characteristics of the interaction in terms of level of participation, control and trust also have an influence on the goal setting process (Bradley et al, 1999).

How do patients view participation in goal setting? A descriptive study (Payton and Nelson, 1996) investigating patients' perceptions of their roles in physiotherapy concludes that patients' perceived participation in goal setting is lower than participation in other aspects of the evaluation and treatment process (programme planning or evaluation). This conclusion is confirmed with a study by the same authors that found that 67% of patients would have liked to be more involved in goal-setting (Payton, Nelson and St. Clair Hobbs, 1998). In a study using interviews with patients, carers and professionals in a neurological care unit, Young, Manmathan and Ward (2008) reported that interviewees perceived goal setting as beneficial, motivating and providing reassurance, while professionals claimed to be more focused and collaborative.

Goal setting can create potential disagreements between participants (Bradley et al, 1999) and dilemmas (Karlsson, 2007). The cases described in Karlsson's discourse analytic study show that when patients cannot formulate a goal, professionals face a dilemma. They need to either make decisions for them, thereby violating the patient's right to self-determination, or to make the dilemma explicit. Yet, Karlsson (2007) argues that those dilemmas were not necessarily problematic, and while their occurrences could not be prevented completely, paternalism might even be a way of enhancing future autonomy as the professionals' actions aimed at benefitting the patients' participation. One of the limitations to increased participation mentioned in Karlsson's argument is time. This observation aligns with the results of another study that showed that goal-setting processes are time consuming and complex (Parry, 2004).

So, in summary, there are preliminary results showing the desire of patients to participate and that empirical evidence shows some benefits in terms of effects, there is still uncertainty about the process: what is the process of goal setting, and how it is

displayed: *what is done* and *how is it done*? This leads us to the review of the literature on the goal setting process.

A handful of studies have analysed in detail the goal setting process and give insight into this process (Parry, 2004; Barnard et al, 2010). These latter studies show that – as in any communicative activity – goal setting involves more than just the provision of information (i.e. exchange of goal information). In addition to that, goal setting needs to be understood as a social action in which goals are shaped through the conversation between therapist and patient. Let us turn now to some of the literature concerning the process of goal setting rather than the outcome and effectiveness of a goal setting approach.

2.3.3.2. The process of goal setting

As suggested in prior sections, most of the interaction research in physiotherapy has been done using a quantitative approach. A recent study (Roberts, Whittle, Cleland and Wald, 2013) used quantitative coding of audio-recordings of the interaction between patients and physiotherapists in an ambulatory care setting. While the authors claim that they have a novel approach, they also reflect on the inadequacy of audio-data without data on the bodily aspects of communication. Roberts et al's (2013) study takes a quantitative approach (RIAS, Roter and Larson, 2002; see Section 3.2.1) to their investigation, which is argued to be less precise and less appropriate for detailed analysis of patient-clinician interaction (Heritage and Maynard, 2006b).

In a qualitative interview study, Slade et al. (2009) found that "all participants expressed the need for mutual enquiry, problem solving, negotiation, and re-negotiation between care-provider and care-seeker to establish mutual therapeutic goals" (p. 237). Patients wanted to be asked for their opinions, goals and personal preferences and allowed to be more assertive about their own needs. In contrast, other interview-based studies have found that patients preferred not to play an active role in goal setting (Hale et al, 2003; Melander and Fältholm, 2006; Conneeley, 2004) as they do not consider themselves to be knowledgable enough to do so.

Evidence suggests that some physiotherapists try to elicit patients' preferences. For patients to get involved in decisions regarding the physiotherapy session, it was observed that physiotherapists used questions such as '*What do you want to work on today*' or '*How would you like to solve this problem'* (Wohlin Wottrich et al, 2004; p. 1202) permitting patients to talk about their needs and preferences. Other physiotherapists tell researchers that they elicit patients' opinion about goals, yet they felt that patients did not participate actively because of their lack of expertise in physiotherapy (Young et al, 2008; Ayana et al. 1998).

It is apparent in the reviewed studies that there exist various obstacles to optimal collaboration. Therapists perceive collaboration with patients to be challenging (Ayana et al, 1998; Conneeley, 2004; Wohlin Wottrich et al, 2004). While a majority of physiotherapists believe that goal setting is important, they encounter difficulties defining the concept (Levack, Taylor et al, 2006). Some therapists consider themselves not up-to-date regarding scientific evidence on efficient ways to treat patients (Wohlin Wottrich et al, 2004). Other obstactles were related to the conciliation between promoting collaboration in goal setting for both short-term and long-term goals (Ayana et al, 1998; Conneeley, 2004). Patients perceived their knowledge to be limited when it comes to knowing about physiotherapy (Melander and Fältholm, 2006; Young et al, 2008) and how to formulate goals (Conneeley, 2004).

So far, no study has been found that explains the reasons that goal setting is not put into practice. Evidence from interview studies describes interactional (Schulman-Green et al, 2006; Wressle et al, 1999) and organisational reasons (Playford et al, 2000) that seem to explain why the goal setting process is not put into practice, even though therapists are convinced of its importance (Baker et al, 2001).

None of the above cited studies, apart from Roberts et al's (2013) study, used observational approaches in order to investigate *how* the process of goal setting takes place. There is one study using conversation analysis that provides some insight into this aspect (Parry, 2004). The study in a neurological setting reveals that physiotherapists

make goals explicit in only 8 out of 74 videotaped treatment sessions. Several hypotheses about why this happens are generated from observations: goal-setting is time-consuming; there are interactional difficulties in discussing patient's problems, and goal-setting assumes that progress is possible, which might not always be the case in stroke physiotherapy.

To summarise, there is an emphasis in policy documentation on collaborative goal setting, with some more or less robust evidence that goal setting has positive effects on outcome, but much is unknown regarding the process. There is evidence from interview studies showing different preferences on participation. Barriers are detected at the organisational (time, consultation structure) as well as at the interactional level (knowledge, expertise, dilemmas). Goal setting is perceived to be a challenging activity, even though patients and professionals deem it important. Studies detected the need for conceptualising goal setting, based on detailed analysis of interaction, rather than accounts about the process. In order to know more about the process of goal setting, an observational approach seems the most pertinent way to find answers to those questions.

2.4. Discussion

In this chapter I discussed several topics in relation to clinical decision-making as an essential part of physiotherapy practice. There is some evidence from the health care literature that collaborative decision-making could improve patient outcomes. This is one of the reasons why shared decision-making is promoted. Some researchers have argued that patients, carers and professionals perceive benefits from this approach. Yet, there is no strong evidence that goal setting in practice has the positive effects that are claimed for it in theory and guidance. Furthermore, there is very little understanding of how goal setting is actually practiced, and accounts from people might not reflect actual practices. It is assumed that people know what counts as collaborative and what shared decision-making looks like.

I further presented theories prevalent in the current rehabilitation literature, policy papers and studies about goal setting in clinical practice. Most of the literature reviewed here shows the overrepresentation of cognitive-behaviourist approach. Yet, influential sociological studies of medical interactions (Heritage and Sefi, 1992; Maynard, 1992; Gill, 1998; Heritage and Maynard, 2006a; Stivers, 2005) shed light on the importance of social aspects of the interaction and the way that something that makes sense in rational terms (*e.g.* goal setting) may present difficulties for actual practice (Heritage, 2011). Several authors highlight the contingencies inherent in social interactions that influence the way discussions develop between patients and professionals. Specifically, for goal setting, investigating those social reasons might help us to understand why professionals and patients find this process less than straightforward.

This study provides an opportunity to investigate the interactional practices that constitute the process of goal setting in patient-physiotherapist encounters. Observations using the method of Conversation Analysis (hereafter CA) serve to identify and understand patterns of interaction (Drew, Chatwin and Collins, 2001). By using video-recordings I am able to fill the gap of methodological limitations when investigating the process of goal setting. CA has the possibility of including both vocal and bodily aspects of interaction and is, therefore, the method of choice for my study.

Chapter 3: Methodology

3.1. Introduction

This chapter presents the methodological aspects of this study. As discussed in Chapter 2, the premise of existing research and policy documents is that patients come to physiotherapy with a goal in mind and that they are able to articulate that goal. So far, I have presented theories and evidence related to goal setting highlighting some of the different methodologies that have been used in the study of goal setting. Before presenting the methodology chosen for my study, namely CA, I turn briefly to the most frequently used methods used for interaction analysis and present their advantages and disadvantages. In the following sections, I go on to present the theoretical aspects of CA, its origin and relationship with Goffman's approach to social interaction and with Garfinkel's ethnomethology. I further elaborate on the empirical aspects of my study, including data collection, transcription and data analysis. I conclude the chapter by summarising the reasons that CA is the appropriate approach for my research questions.

3.2. Interaction analysis in health care

If we stand back and look over the research based in medical settings, we can see that there has been extensive literature on interactions between lay-persons and health professionals. Different approaches can be chosen in order to investigate social interactions: quantitative approaches such as Roter's Interaction Analysis System (RIAS), qualitative approaches including ethnography or phenomenology, or - as is the case in my study - CA, an inductive, observational approach. In health care research today, a positivist paradigm is predominant, and the acceptable 'scientific' approach to physiotherapy is the positivist epistemology using quantitative research methods.

Positivist epistemology (the bases for RIAS) pursues empirical facts that correspond directly to reality, undistorted by the observer's expectations or ideas, while interpretive epistemology (phenomenology, ethnography) understands our world foremost as a

world of ideas about ourselves, society and nature. Researchers themselves are an integral part of these social worlds.

Giacomini (2010) illustrates health research traditions and the differences between ontology and epistemology in the following Figure 3.1.

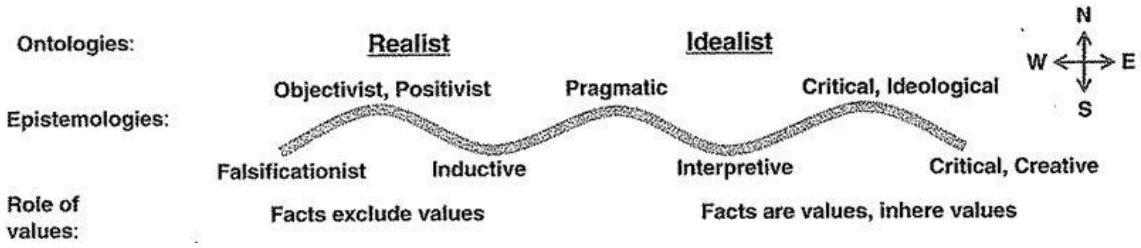


Figure 3.1. Health Research Traditions (Giacomini, 2010; p. 130)

What ontological and epistemological position CA is taken, is a matter of debate. Conversation Analysts like to see themselves as researchers 'doing CA', rather than thinking about ontogical and epistemological foundation of CA. I will not attempt to enter this debate here, but leave this to more advanced scholars.

In Sections 3.2.1. and 3.2.2. I review the advantages and disadvantages of the quantitative and qualitative approaches to interaction research, before presenting in Section 3.2.3. conversation analytic studies of health care interactions.

3.2.1. Quantitative approaches - Roter's Interaction Analysis System (RIAS)

Starting with the most frequently used framework, the positivist paradigm, we find at the heart of this philosophy the belief that interactions should be measured in order to ensure 'objectivity'. Several coding systems have been developed in recent years. Among existing 'interaction analysis systems' (IAS), Roter's Interaction Analysis System RIAS (Roter and Larson, 2002) is now the most frequently used coding system in clinical research. It provides a quantitative measure of interaction between physicians and patients and consists of 29 categories related to question-asking and information-giving, and 14 categories concerned with socio-emotional aspects of an interaction. The advantage of this system is that statistical analysis can be performed and comparison be made across studies (Roter and Larson, 2002). However, because utterances are coded

or counted one by one (and each participant is coded separately), the analysis of interactivity is sacrificed (Heritage and Maynard, 2006a). Other researchers criticise the fact that silences and pauses are not included as functional criteria (Sandvik et al, 2002). Therefore, the ability of RIAS to adequately describe the interaction between patient and professional is questionable. There have been attempts to improve the categories by mixing RIAS with CA (Sator et al, 2012), but this amalgam is still not used widely.

In physiotherapy, the quantitative approaches to communication and interaction remain paramount. As presented in Section 2.3.3. a very recent study investigating verbal communication in initial physiotherapy encounters (Roberts et al, 2013) used an existing quantifiable coding system (Medical Communications Behavior System, MCBS) and the computer programme Synote to measure verbal content of the interactions of patients and therapists. There are several problems with this approach. First, claiming ethical concerns, the authors decided to use audio-recordings only even though bodily communication is a key part of physiotherapy work (Martin, 2004). As my study shows, if ethical concerns are tackled up front (see Section 3.5.3), there is minimal risk and no concerns from participants. Second, the categories used in the MCBS are very broad, not taking into consideration the interaction between participants, but each participant separately (Heritage and Maynard, 2006a). Third, it is also unclear how subcategories such as advice, suggestions, or information are defined and distinguished from one another; findings from prior CA studies have shown that those categories are very complex (Pilnick, 1999).

Table 3.1 and 3.2 below provides an overview of the therapist and patient related categories as applied in Roberts et al's study (2013, pp. 486 – 487).

Table 3.1. Therapist related categories of Medical Communications Behavior System (MCBS)

Physical Therapist Content Behaviors	**Physical Therapist Affective Behavior**	**Physical Therapist Negative Behavior**
- History / background probes - Checks for understanding / information - Advice / suggestion - Restatement - Clarification	- Emotional probes - Reassurance / support - Reflection of feelings - Encourages / acknowledges	- Disapproval - Disruptions - Jargon

According to this approach, the analyst is required to code the therapists' behaviour as belonging to one of three mutually exclusive groups: content behaviour, affective behaviour and negative behaviour. This mutual exclusivity is problematic as people regularly do more than one thing at the same time, and that interactional organisation of talk can override the content (Maynard, 2003). It is, therefore, challenging to differentiate utterances into, for example, 'content behaviour' or 'affective behaviour'. Additionally, the category 'negative behaviour' is also problematic. For instance, we know from CA studies that 'disruptions' (the term used in the MCBS for overlapping talk), can have different functions and some of these could be seen as evidently affilitative rather than 'negative'. Lerner (1989) describes one type of overlap, 'delayed completion', in which a speaker delays the final part of the utterance after the other participant has already started her/his turn. I assume that this case would fall into the category 'disruption', however, as Lerner (1989) suggests, this overlap could be also understood as the "projectability of possible completion" (p. 168), hence participants being sensitive to other's talk. In this sense, it could not be considered 'negative behaviour'.

Table 3.2. provides the same three categories for patients' behaviour with an additional fourth category 'miscellaneous'.

Table 3.2. Patient related categories of Medical Communications Behavior System (MCBS)

Patient Content Behaviors	**Patient Affective Behavior**	**Patient Negative Behavior**	**Miscellaneous**
- Content questions - Content remarks - Checks for understanding / information	- Encourages - Emotional expressions	- Disapproval - Disruptions	- Social amenities - Silence - Unclassifiable

The same criticism applies to the labels used to categorise therapists' behaviour. Furthermore, in including silence within the category 'miscellaneous' the system seems to suggest that silence is a particular feature of patients' talk. First of all, 'silence' might be the 'absence of talk', but it does not mean that there is nothing happening interactionally: there might be a gaze exchanged between participants, a gesture or other activities such as writing might be concurrently performed.

For all these reasons, I question the approach of Roberts et al's study and whether it makes sense to measure interaction using the categories named above. I argue that social interaction is more complex than measuring the percentage of pre-established categories and 'putting talk into boxes'. In order to adequately understand interaction, focus should be put on interactivity (not categorising participants separately), vocal and bodily resources used by participants to accomplish their activities and provide a detailed description of how participants themselves make sense of the other's action. In the next section, I turn to qualitative approaches and present the principles of this scientific approach.

3.2.2. Qualitative approaches such as ethnography or phenomenology

In Section 1.3 I reviewed studies investigating patients' and/or professionals' perceptions of the interaction, with a particular focus on goal setting. Those phenomenolocial studies have the advantage of giving participants a voice and shedding light onto subjective experiences lived or perceived by persons. It is assumed that there are multiple realities, and that reality is socially constructed (Giacomini, 2010). One of

the pitfalls of this approach to goal setting is the mistake of thinking that talking about an interaction and participating in the interaction are the same things (Heritage, 1984). It cannot be assumed that when patients and professionals talk about their experiences or their perceptions about the goal setting process, that the accounts of the participants would match that of an observer of the interaction.

Another qualitative methodology within the interpretive epistemology used for the purpose of interaction analysis is ethnography. Thornquist (1994) analysed the patient-physiotherapist interaction in three different speciality areas, namely home physiotherapy, psychomotor therapy and manual therapy. Applying Mishler's model of patient's perspective ('life world') and the biomedical perspective ('world of medicine'), the author describes the practice of musculoskeletal therapists who either include or block the patient's 'life world'. The problem with this analytical approach lies in the creation of a pre-set analytical framework. The particularities of the interaction cannot be captured completely due to the pre-established categories limiting the depth of the analysis (Parry, 2001). While not all ethnographies use pre-determined categories, ethnographic observations have limitations because researchers have to rely on their fieldnotes and memory to reconstruct the interaction. Without recordings, the detailed and repeated scrutiny of interaction, including bodily aspects of talk, is just not possible.

Therefore, both quantitative coding systems (positivist paradigm) as well as interpretive approaches (ethnography, phenomenology) have significant limitations. The third option used for interaction analysis is the approach of CA, which I will review now in more detail.

3.2.3. Conversation analytic studies of health care interactions

In the field of interactional studies, one of the most important bodies of conversation analytic research in health care published in recent years is reported in the book "Communication in Medical Care: Interaction between primary care physicians and patients" (Heritage and Maynard, 2006a). There is a range of topics investigating how patients present their concerns (Robinson, 2006), how physicians present news

(Maynard and Frankel, 2006) or communicate diagnoses (Peräkylä, 2006), how physicians take the patients' history (Boyd and Heritage, 2006) and how medical encounters are closed (West. 2006).

Another topic tackled from a CA perspective is patient participation (Collins et al, 2007), which I have already touched on in the literature review (Chapter 2). The fine-grained analysis presented in these studies helps establish understanding of the communication patterns used in health care interactions. Conversation analytic studies are able to provide evidence by using data from naturally occurring interactions and thereby are able to give insight into how participants themselves orient to the unfolding interaction. As CA is a 'young' approach (Heritage and Maynard, 2006b), reviewing and synthesising CA work is in its infancy (Parry and Land, 2013). This is a promising approach for synthesising discourse and conversation analytic study to inform practice, policy and research. Furthermore, as evidence from detailed analysis becomes more robust, randomised controlled trials are designed to test the theory and make generalisation from a sample to a population. One example is Heritage et al's (2007) innovative intervention study on the use of the words "any" versus "some" in the question "Is there *anything*/*something* else you want to address in the visit today?" to elicit patients' concerns. The results indicate that patients' unmet concern was reduced when physicians used the word "some". These developments of CA show that, while more is to come in the next few years, these types of studies certainly have importance and credibility in understanding health care interactions.

I have shown in this section that there are different types of philosophical assumptions underlying the different methodologies used in health care interaction studies. In the following sections, I present in detail the theoretical foundations of CA and how it was inspired by Erving Goffman's work and by Harold Garfinkel's Ethnomethodology, which laid the groundwork for CA. Ethnomethodology has been described as the intellectual framework of CA (ten Have, 2004) while Goffman's approach to face-to-face interactions helped develop an investigation of those social

phenomena in the first place (Maynard, 2013). With this in mind, I proceed now to Goffman's theory of the interaction order, followed by an overview of Garfinkel's Ethnomethodology.

3.3. Theoretical aspects of Conversation Analysis

3.3.1. Goffman's interaction order

Erving Goffman has been highly influential within the field of interactional sociology (Branaman, 2003). Goffman (1983) insisted on the importance of analysing face-to-face interactions and promoted interaction as a domain for study in its own right. By isolating the domain of the 'interaction order' it was possible to provide "a means and a reason to examine diverse societies comparatively" (Goffman, 1983, p. 2). He further argued that social interaction embedded an institutional order (Heritage, 2001), and he privileged this approach of analysis rather than using pre-established categories such as socioeconomic class, gender or ethnicity for understanding social interaction (Maynard and Peräkyla, 2003). The following are the main themes of Goffman's work in the study of social interaction (Branaman, 2003; p. 87):

1) the self as a product of performance of everyday social interaction;

2) the tendencies of participants to conserve everyday interactional norms; and

3) their tactics to resist, challenge, or maintain face.

Everyday life as a performance was the key issue when Goffman (1959) described the structures of social life in '*The presentation of self in everyday life'*. He developed an explanation based on dramaturgical metaphors in which individuals in society assume one of the following roles: performer, audience or outsider. In addition to roles, the performance location, backstage vs. front region, becomes relevant for human interactions. He further provided keys for understanding "appearance" and social interaction when he stated that "the performance of an individual in a front region may be seen as an effort to give the appearance that his activity in the region maintains and embodies certain standards" (Goffman, 1959, p. 110). Through those metaphors,

Goffman's approach made the investigation of the microsociology of interaction accessible.

The second key concept Goffman developed was the maintenance of 'face'. In his view 'face' was central to the organisation of social interaction, as participants socially position themselves to one another in order to maintain 'face' (Sidnell, 2010). Two basic rules govern this concept: on the one hand the rule of self-respect, which refers to how others see the person act in a certain way, and the rule of considerateness, which relates to how individuals are tactful towards the other (Branaman, 2003).

Goffman developed a detailed analysis of strategies to describe people's action to maintain dignity and self-respect (Branaman, 2003). Those strategies are based on the background that "interactions are usually orderly, routine and predictable" (Manning, 1992). In Goffman's (1963) work *Stigma*, he goes a step further and analyses how individuals who do not follow certain rules behave.

> "The stigmatized individual is asked to act as to imply neither that his burden is heavy nor that bearing it has made him different from us; at the same time he must keep himself at that remove from us which ensures our painlessly being able to confirm this belief about him. Put differently, he is advised to reciprocate naturally with an acceptance of himself and us, an acceptance of him that we have not quite extended him in the first place." (p. 76)

The main point Goffman is making here is that the concept of 'deviation' is the bridge linking the study of stigma to the study of the social world. Using deviations and extremes bridges the gap for understanding the normality (Willems, 2009). Goffman understands that social 'rules' are realised through negotiation and improvisation, and are not "inflexible determinants of behaviour" (Jenkins, 2010, p. 258)

Finally, the highlight of Goffman's career, according to Willems (2009), was his book '*Frame Analysis'* (Goffman, 1974) in which he managed to formalise a "meta-schema" of his analytic description of the interaction order (Willems, 2009; p. 50). Baptista (2003) explains the framing of a situation as follows:

> "The framing of a situation is the answer to the question "What is going on here?". A "proper" answer allows the participants to orient themselves and monitor their (and others') display of behavior – procedures that, on their part, are essential to maintain and/or reproduce a given frame" (p. 197)

People orient themselves to a given situation. Goffman investigated the ways in which participants make sense of each other's actions, including continuous monitoring of behaviour (Baptista, 2003). '*Frame analysis'* brings back some of the themes covered in '*The presentation of self'*, yet without the need for using dramaturgical metaphors (Manning, 1992)

In sum, Goffman was able to help us see, as Schegloff (1988) puts it, that social interactions "were investigable things" (p. 90) and that they could be examined in detail. He offered an investigation of interactional processes in a natural environment (Willems, 2009). By introducing the concept of 'face' and 'impression management' and the idea of 'rule'-governed social interaction, Goffman was able to give us keys to read human behaviour in social interactions. To consider the self as a product of performance, and to understand the participants conserving everyday interactional norms, and their strategies to maintain or save face, are fundamental to Goffman's theory of interaction order (Branaman, 1992).

Yet, Goffman's approach also has some shortcomings: his work was not based on systematic investigation of recordings of actual interactions (Heritage, 2001). Schegloff (1988) argues that Goffman did not work empirically and used invented examples, although Goffman frequently referred to his ethnographic studies. This lack of a systematic analysis of interactional data, a crucial difference between Goffman's approach and CA (Schegloff, 1988), however, was filled by an alternative to investigating social interactions, namely by Garfinkel's Ethnomethodology.

3.3.2. Ethnomethodology

While Goffman's interaction order provided an entry point for investigating social interaction, Ethnomethodology (hereafter EM) provided the necessary methodological tools to carry out such an investigation. The word Ethnomethodolgy is composed of the prefix "ethno" (= people, common sense knowledge), the word "method" (= practices, to make sense of the world) and the suffix "ology" (= the study of; Bergmann, 2009; p. 51). EM is interested in understanding methods and practices participants use "to produce and recognize courses of social activity" (Maynard and Clayman, 2003; p. 174). EM is also described as "folk methods"(Rawls, 2006; p. 1) as it aims to explicate how people "create and maintain a sense of order and intelligibility in social life" (ten Have, 2004, p.14). This approach is quite different from any other "realist" philosophy. The particularity of this methodology is that the inquiry about the social world does not start with existing theories, but with experiences of the social world in daily life. While adopting a "bottom-up" approach EM tries to "recover social organization as an emergent achievement that results from the concerted efforts of societal members acting within local situations" (Maynard and Clayman, 2003, p.174).

Garfinkel is known as the 'founder' of EM and his work has to be understood in the context of Goffman's interaction order and Schutz's phenomenology. While Garfinkel was influenced by Talcott Parsons and his work '*The Structure of Social Action'*, he was also dissatisfied with it (Heritage, 1984). Garfinkel questioned the usefulness of "objectively rational actions" (p. 33) and was convinced that the judgments of social actors were not irrelevant, but actually key to "the maintenance of social organisation" (Heritage, 1984; p. 34). As Garfinkel was searching for the answer to the question about social order and how it worked, he turned to Schutz's writing about phenomenology. Schutz "developed a stance towards the nature of meaningful action which dealt directly with the themes of the actor's knowledge and its intersubjective character" (Heritage, 1984, p. 38). According to Heritage (1984) Schutz insisted on the importance of common-sense knowledge - shared and socialised - as a vehicle for 'Verstehen' (understanding the meaning of action). This 'sense-making' is not a private and unobservable process, but an

object for scientific enquiry. The link to Garfinkel's approach can be found in the "problem of intersubjectivity": according to Schutz, "human beings can never have identical experiences of anything, but that this is irrelevant because they continuously assume that their experiences of the world are similar and act as if their experiences were identical-for-all-practical-purposes" (Heritage, 1984, p. 54). Ethnomethodological investigation took the approach from Schutz with regard to the investigation of what intersubjective knowledge and understanding is and how it is achieved (Heritage, 1984).

The assumptions underlying EM are that social life is structured and ordered, and that it is continually constructed and communicated by the actors (Eberle, 2007). There are two main features of EM: **indexicality** and **accountability**.

Indexicality means that language use and social action are context-dependent (Arminen, 2005). Indexical expressions are defined as "those whose sense depends on the local circumstances in which they are uttered and/or those to which they apply" (ten Have, 2004, p. 21). In any situation we bring meaning to the world, and it can be argued that meaning is dependent on the situation.

Accountability takes into consideration the fact that actions are designed in order to be understood, so that they are intelligible. The aim of CA is "to identify precisely those methods, procedures, or practices that enable participants to construct their talk to do, and to be recognized as doing, what they mean to be doing" (Drew, 2005, p. 94).

The influence of Goffman can be tracked back to the investigation of social order, and Garfinkel's methods, by using both indexicality and accountabililty, enabled some of Goffman's and Garfinkel's students to develop the concept further and elaborate CA.

3.4. Conversation Analysis

CA was developed by Harvey Sacks in collaboration with Emanuel Schegloff and Gail Jefferson (ten Have, 2004). It can be said that "it is both an interpretive enterprise seeking to capture the understandings and orientations displayed by the participants

themselves, and at the same time it enforces rigorous standards of evidence made possible by the use of recorded data" (Clayman and Gill, 2004, p.590).

The theory underlying CA is that "previous actions are a primary aspect of the context of action, that meaning of an action is heavily shaped by the sequence of the previous action, and that social context itself is a dynamically created thing that is expressed in and through the sequential organisation interaction" (Heritage, 2005, p.104). Three claims are made:

- talk is context shaped: participants address themselves to preceding talk
- talk is context-renewing: participants project and require what next action should be
- mutual understanding is created through sequential architecture of intersubjectivity

Talk and other actions can be understood as sequentially organised and ordered. Participants in the interaction use as a resource the relationships between turns and other moves in order to understand the sense of the on-going action (Arminen, 2005). Here we find the link to the overarching theory of EM.

The key features of CA are that the data is naturally occurring, meaning that the interaction is not set up for the research, but interaction would happen in any case (e.g. physiotherapy treatment for patients), and that the phenomena are not coded, and of qualitative nature (Drew, 2005).

Having outlined the general principles of CA, I highlight in the next section the particularities of institutional settings (medical interactions, court rooms, classrooms, etc.) before describing CA's analytic approach to data.

3.4.1. Institutional CA

Early work in CA has focused mainly on ordinary conversation. Further developments include data from institutional settings like doctor-patient interaction

(Heritage and Maynard, 2006b), counselling sessions (Peräkylä, Ruusuvuori and Lindfors, 2007) or trial examinations (Drew, 1992). Differences can be noted between basic CA (analysing ordinary conversation) and institutional talk (sometimes referred to as applied CA). While basic CA "specifies the normative structures and logics of particular courses of social action" (p. 104), institutional CA, building on findings of basic CA, "examines the operation of social institutions in talk" (Heritage, 2005, p.104).

A way to analyse the specificity of an institutional context is to investigate "the procedural connection between the context and what actually happens in talk through comparing "sequences of that sort in the institutional and mundane contexts" (Arminen, 2005, p. 47). Arminen suggests that studies of institutional interactions might benefit from "closer attention to background knowledges and sets of beliefs that may be the relevant sources informing the ways subjects apparently, but perhaps not obviously, design their actions" (p. 57). However, it should be kept in mind that CA does not see context as an a priori framework in which activities take place, but rather CA sees context as a product that the participants create through their actions and activities (Heath and Hindmarsh, 2002).

The three elements constituting institutional talk (Heritage, 2005) are as follows:

1. The interaction involves goals that are tied to institutional relevant identities
2. The interaction involves special constraints on what is an allowable contribution to the business at hand
3. The interaction will involve special inferences that are particular to specific contexts (p. 106)

Yet, it is not always easy to distinguish ordinary talk from institutional talk. Heritage (2005) argues that "institutional talk can occur anywhere, and by the same token, ordinary conversation can emerge in almost any institutional context" (p. 107). The purpose of CA in an institutional context (e.g. orthopaedic physiotherapy) is to describe different aspects of talk related to sequences, in particular **turn-taking**,

structural organization, **sequence organization**, **turn-organization**, **lexical choice** and forms of **asymmetries** during the interaction (Heritage, 2004, 2005; Hindmarsh and Llewellyn, 2010). Let us look at the specific features of each of those aspects:

- Turn-taking organisation: participants use special turn-taking practices and procedures (e.g. question-answer during examination activity) and are expected to follow certain rules (e.g. answering the questions, telling the story of how accident happened).
- Structural organisation: analysis of different sections and phases of interaction recurring across occasions (e.g. opening – greeting, problem initiation, arrangement making, closing).
- Sequence organisation: analysis of how actions are initiated, followed through and closed and how participants exhibit their understanding of activities (e.g. goal setting activity)
- Turn-design: analysis of how alternative ways of saying (or doing in case of non-verbal communication) are selected, how aspects of turns are articulated with the performance of organisational tasks, and how design of turns accomplishes organisational work (e.g. how goal setting is initiated and included in the physiotherapy evaluation and treatment process).
- Lexical choice: analysis of vocabulary used and how institutional nature of activity is revealed
- Forms of asymmetries: analysis of participation, knowledge and rights of access to knowledge (e.g. physiotherapist expertise vs. patient expertise).

I now review the most relevant dimensions for my study, namely turn-taking organisation, overall structural organisation, sequence organisation, and asymmetries.

3.4.2. Turn-taking organisation

In conversations, there is the general norm that participants do not constantly overlap in talk, but talk "one at a time" (Sacks, Schegloff and Jefferson, 1974). As described in Sacks et al's seminal paper, talk is fundamentally ordered, and participants

use a variety of practices to manage turn-taking so that long pauses are avoided and they do not continuously talk over one another (Hindmarsh and Llewellyn, 2010). While the size of the turn and the length of the turn are not fixed (Sacks et al, 1974), there are practices for participants to "assess when someone's turn is coming to completion" (Hindmarsh and Llewellyn, 2010, p. 33). The turn-taking system is therefore locally managed (organised on a turn-by-turn basis) and party-administered (participants themselves determine size of turns and length of conversations; ten Have, 1999; Sidnell, 2010).

Let me give an example of a sequence from my data in which we see how turns are taken. In this extract the turn-taking is one-at-a-time, with minimal pauses and an overlap when completion of turn is expected.

Extract 3.1: G02 PTn Rx1_00.18 (simplified translated transcript)

1 Physio	Why are you here.
2	(0.4)
3 Patient	Pardon?
4 Physio	Why are you here (.) what would you like.
5	(0.2)
6 Patient	Well I would like- yes I would like to be treated
7 Physio	>Pardon?<
8 Patient	I would like to be treat[ed]
9 Physio	[↑Yes] (.) and what is the goal.
10	(0.9)
11 Patient	That I can go back to work fully
12	(0.6)
13 Physio	This is a good goal
14 Patient	Yes

First of all, this extract shows that participants talk mostly without overlap. When the therapist asks the patient for his reason for coming to physiotherapy (line 1), the patient responds after 0.4 sec with "*pardon?*" indicating thereby his understanding that a response should be forthcoming. The therapist repeats his question "*why are you here*" followed by "*what would you like*" (line 4) to which the patient responds with "*well I would like- yes I would like to be treated*" (line 6). In this part of the sequence we see the organisation of turns: when a question is asked by a participant, an answer is due.

The second feature to highlight in the second part of the sequence is the overlap. After a repetition of "*I would like to be treated*" (line 8) the physiotherapist comes in in overlap "*↑Yes and what is the goal*" (line 9). The "yes" in overlap is not an interruption per se, but a projection that the prior turn comes to a close. Those moments in which the transition to the next speaker becomes relevant are called "transition-relevant places" (Schegloff, 2007a).

Turn-taking is important for talk-in-interaction as this is where the "locally sensitive fine-tuning" occurs (ten Have, 1999; p. 112) and where rights and obligations of turns get distributed (i.e. speaker selection, Sidnell, 2010). It should be noted that turn construction is collective work done by all participants, and joint productions of turns are not uncommon (Gülich and Mondada, 2008).

3.4.3. Overall structural organisation

The overall structural organisation concerns the phases of conversation and can be understood as a "supra-sequential coherence" (Robinson, 2013, p. 258). There are several terms used to describe the structural organisation of sequences. While Robinson (2003) talks about "project of activity", Heritage and Sorjonen (1994) use "activities" to describe multiple sequences of actions. It is generally understood that in a single occasion of interaction, there is an organisation such as having "an opening", "a closing" and "something in between" called "topic" (Robinson, 2013).

> The "overall structural organisation embodies a source of context, and provides a source interactional coherence, that shapes and constrains participants' production and understanding of behaviour in interaction, and that is relatively external to the more local sources provided by, for example, turn and sequence organization. Overall structural organisation frequently imposes the onus of progressivity through the structure and its components toward completion, and provides the resource of projectability regarding completion of the structure and its components. (Robinson, 2013, p. 278)

Schegloff (2011) argues that units of organisation have "both a local organization, which operates via progressivity form one sub-unit to the next" and "an overall structural organization" (p. 378). I will draw on the concept of overall structural organisation in order to examine at what moment goal setting takes place and what the consequences are interactionally.

3.4.4. Sequence organisation

Sequence organisation is another key dimension for CA, which is referred to as "one thing can lead to another" (ten Have, 1999, p. 113). The main analytic point is to consider how pairs are organised, for example how questions and answers are formulated, and thereby help understand the functioning of organisations (Hindmarsh and Llewellyn, 2010). It is common for talk to refer back to what has been discussed in the prior turn (Gülich and Mondada, 2008). The question-response pair (also called an "adjacency pair") is characterised by the following features: (1) it is two turns long; (2) different speakers produce each utterance; (3) placed one after the other (adjacent); (4) relatively ordered (e.g. question – answer); (5) pair-related (Schegloff, 2007a).

In Extract 3.1. an adjacency pair can be identified in lines 4 and 5. The therapist asks a question to which the patient gives a response.

4 Physio	Why are you here (.) what would you like.
5 Patient	Well I would like- yes I would like to be treated

While adjacency pairs make the next turn relevant, an absence of a response after a question will be noticed and oriented to. In the next Extract, the therapist repeats her question when the patient's response is not forthcoming.

Extract 3.2: B03 PTc Rx1_22.34 (simplified transcript)

1 Physio	Well your goal or your expectation for physiotherapy (.) >you said that the ↑physician would like to have the strength improved<
2	(0.5)
3 Physio	e::::hm
4	(1.6)
5 Physio	Your goal or your expectation
6	(1.7)
7 Patient	↓Well it is just (.) that I know in principle (.) what I can do by myself as well [can't I]
8 Physio	[↑Mhm]

The therapist asks the patient what she expects from physiotherapy instead of asking her about the physician's goals (line 1). After a short pause, a hesitation marker (line 3) and another pause in which the patient does not respond, the physiotherapist asks the question about goals and expectations again (line 5). This time the patient – although after a delay of 1.7 seconds – responds with "*well it is just that I know in principle what I can do by myself as well, can't I*" (line 7). This response is acknowledged by the therapist (line 8).

Sequence organisation, and in particular adjacency pairs are at the heart of my investigation. Health care interactions are predominantly accomplished through questions, and history-taking as well as a diagnosis are shaped by how questions are posed and responses are given. Freed and Ehrlich (2010) dedicated a whole book to the function of questions in institutional contexts, with half of the chapters about health care interactions. As ten Have (1999) points out, the relationships between pairs is "a normative one" (p. 113). As shown in Extract 3.2., the patient is treated as accountable to give a response. In addition to that, adjacency pairs are important for intersubjectivity

(Heritage, 1984): the next turn shows clearly if the prior turn was understood, and if necessary can be corrected (ten Have, 1999).

3.4.5. Asymmetries

Asymmetries between participants in institutional contexts can be related to knowledge, experiences of organisational practices or information (Hindmarsh and Llewellyn, 2010). Asymmetries are grounded in the sequential organisation of social interactions (Enfield, 2011). In social interactions there is "a dynamic relation between a communicative action and the response it elicits" (p. 186), and both action and response are interdependent (Enfield, 2011). The analysis of turns and sequences in detail provides insight into rights and responsibility with regards to asymmetries in social interactions (Stivers, Mondada and Svennevig, 2011).

In sum, in Section 3.2.1 I argued that preconceived hypotheses might not be adequate for understanding what is really happening in social interaction. CA has the tools to shed light on social actions and how participants use practices to make sense of the actions of co-participants. Heath and Hindmarsh (2002, p. 11) summarised the benefits of CA in three main points:

1. Talk and bodily conduct are social actions and are the primary vehicles through which people accomplish social activities and events.
2. The sense and significance of social actions and activities are inseparable from the immediate context; they emerge moment by moment reflexively creating the context in which they arise.
3. Participants use and rely upon practices, procedures and reasoning, in short 'methodological resources', through which they produce social actions and make sense of the actions of others.

Using CA enables us to generate a better understanding of social practices within a certain institutional context. The method allows description of the organised structures

and patterns that underlie a meaningful communication. The next section explains the details of empirical aspects of my study.

3.5. Empirical aspects of the study

In this section I describe how I designed and undertook my study. Yet, before I can enter the description of a systematic investigation, there is one issue that requires attention. What is my position in the field (as a clinician, as a sociologist) and how do I reflect about the insider/outsider? Table 3.3 summarises the potential advantages and disadvantages of insider positions

Table 3.3: Potential advantages and disadvantages of insider positions (Chavez, 2008)

Potential advantages of insider position	Complications of insider position
- Nuanced perspective for observation, interpretation and representation - Equalized relationship between researcher and participants - Quick rapport building - Immediate legitimacy in the field - Easier access to the field - Knowledge of historical and practical happenings in the field - Facilitation of natural interaction and behavior - Insights into linguistic principles of participants	- Over-identification with the field - Difficulties with double role as researcher and community member - Participants' perceptions and expectations can support or constrain researchers' role - Limited access to "political" climate - Difficulties recognizing patterns due to blind spots

Whether positionality, insider or outsider, affords advantages or disadvantages for a certain project depends on the research question and the context of research. Some of the advantages of being an insider were obvious. I had an easy access to the field, as well as legitimacy due to prior experience and collaborations. I had an extensive understanding not only of the professional practices in general, but specifically of both sites, having worked at these sites and so being familiar with documents, processes and institutional culture.

The disadvantages, however, are also evident and required some precautions. It was not always easy to keep the role as a researcher and participating therapists sometimes wanted to get my view on treatment intervention or on the patients' evolution. During those situations, I tried not to assume this 'expert therapist' position;

instead of giving suggestions, I only asked questions. Yet, I had to strike a balance to keep a positive relationship with the participants and to 'stay out of the picture'. I would like to mention as well that those moments were always 'off-camera' and happened when the patient had already gone and I was still cleaning up. As CA uses principally the video recordings as data to analyse members' own understanding during the interaction, those discussions afterward might be less relevant.

A second disadvantage was that – with my insider knowledge of the sites and some participants – I would not be able to identify members' practices as such, but rather being influenced by my own experiences. In order to remedy this, I organized several workshops with physiotherapists, psychologists and sociologists providing insight into different work contexts (other physiotherapists) and "reading of the data". Collaborative viewing of data helps neutralize preconceived notions (Jordan and Henderson, 1995), and increases the understanding of the phenomenon and its meaning (Parry, 2010).

Having clarified my position in the field and how I dealt with the inconveniences of being an insider, I turn now to the seven methodological rules for CA described by Silverman (1998, p. 62 – 67) that I found useful and inspiring, yet challenging:

1. Gather observational data
2. Making recordings
3. Being behaviourist: turn "away from the inside of people's head and towards their observable activities" (p. 62) in order to "elucidate how members did whatever they did" (p. 63).
4. Members' method: researchers should only identify activities if they are produced as such by participants
5. Concepts in social science: Sacks' concept is not "a set of hypothetical constructs" but claims to "be dealing with the real world" (p. 64)
6. Locating the machinery: the rules and procedures help members to bring order and thereby use utterances to "display an understanding of something" (p. 66).

7. Building a data analysis: Sacks' investigation of data is always a "cumulative enterprise where one finding leads to another" with the goal to "tie things together" (p. 67).

To start with, the first two points were the easy ones. To gather observational data and to make recordings is mainly a matter of organisational skills, access and technical knowledge. However, to learn 'the trade' is quite challenging. I struggled not to interpret what participants might be thinking (point 3), and to understand what they were doing (point 4). To find order (point 6) and tie things together (point 7) were the most challenging tasks.

Let me now go into more details and present the setting of the study and how I selected participants. I then describe the ethical aspects I took into consideration, before I elaborate in detail the data collection, transcription and analysis.

3.5.1. Setting of the study

Two orthopaedic physiotherapy outpatient settings in German-speaking Switzerland were selected to be part of the study. The first site is the regional hospital in a small city (approximately 15'000 inhabitants). The hospital has 350 beds with a specialised neurological and geriatric unit. The ambulatory care centre provides treatments for discharged inpatients as well as patients referred by their primary care physician. The 24 physiotherapists working in this institution treat inpatients as well as outpatients. There is a mix of novice and experienced physiotherapists, and it is also a clinical education site for Swiss and Belgian physiotherapy schools. A few years back I worked there for more than five years and have, therefore, insider knowledge of the organisation. The leadership (head of the department, three group leaders) has not changed since then.

The second site is a privately owned practice in a small city (about 16,000 inhabitants) about 20 kilometres west of the other site. The culture in a private practice is quite different and more individualised where physiotherapists treat patients mainly in private rooms. There are seven experienced physiotherapists with specialised knowledge

in manual therapy working at this site. Most of them also teach postgraduate courses throughout Europe.

The choice of the settings was of a practical nature, but also of strategic interest (two different practice settings, novice and expert physiotherapists). Two different institutions allow for a more diverse data collection, including different contexts of orthopaedic physiotherapy practice (mid-size hospital, and private practices).

Private practice

The therapists in private practice worked mainly in two areas. One was a private treatment room with a table and a bed and a window with daylight. Therapists working here were able to have a private talk as they worked in a closed room (as compared to the hospital setting).

The other working area for treating patients was a gymnasium, which included some fitness equipment and a bed for examination (bed not shown).

Gym

District Hospital

Therapists at the hospital site worked behind curtains, especially for all initial consultations as well as passive treatments. They also had the option to use a gym and a separate fitness room; however, these were not often used during data collection.

3.5.2. Selection of participants

All physiotherapists at the two sites were invited to participate, and 10 physiotherapists in total were recruited (out of 29 in total: 22 in hospital setting and 7 in private practice). Patients with musculoskeletal problems scheduled to receive physiotherapy by one of the participating physiotherapists were asked to take part in the study. In total 11 physiotherapists agreed to participate, one therapist (PTa) was involved in the pilot study. I was able to recruit more experienced therapists (especially in private practice), but at the hospital site one novice also participated. Table 3.3. provides an overview of the recruited therapists.

Table 3.3: Characteristics of physiotherapy participants

Code	Site	Specialisation	Experience
PTa	Hospital	Manual therapist	20 years
PTb		Manual therapist	7 years
PTc		Generalist	17 years
PTd		Novice	1 years
Pte		Generalist	6 years
PTf		Feldenkrais[6]	10 years
PTg		Manual therapist	17 years
PTk	Private practice	Manual therapist	20 years
PTl		Manual therapist / sports therapist	30 years
PTm		Manual therapist	10 years
PTn		Manual therapist / teacher	30 years

[6] Feldenkrais is an educational method to improve function by learning how to move efficiently and with ease (Kolt and McConville, 2000).

Details on the selection process are described in detail in Appendix C. Inclusion criteria for patients were the following:

- more than 18 years old
- able to communicate in German
- musculoskeletal problem is the main reason why the patient seeks physiotherapy services
- willingness to participate in the study when sessions are video-taped

In total, 28 patients with common musculoskeletal problems were included at the two sites (see Appendix F). Patients who were invited most often accepted the invitation to participate. Only one patient who was approached decided not to participate. In order to prepare them and inform them about the study, I had to obtain ethical approval from the local Ethics Committee.

3.5.3. Ethical considerations

Ethics committee approval had to be granted by the Cantonal committee (Ethikkommission of Canton of Solothurn/Aargau). Informed consent was obtained separately from patients and physiotherapists prior to recording (see Appendix A and B – Information sheet and Consent form in German only). The information sheet includes a presentation of the project (see Appendix under heading: 'Allgemeine Informationen zur Studie') and its procedure ('Ablauf der Studie'), eventual risks and inconveniences, as well as benefits of the research projects ('Nutzen und Risiken' and 'Einschränkungen'). Further there was information about participants' voluntary participation ('Teilnahme'), confidentiality of data ('Vertraulichkeit der Daten') and contact information ('Kontaktpersonen') both at the site and my own. The informed consent form had two pages, the first page with a signed general agreement to the study and the second page with specific level of release. I asked participants to give me detailed authorisation as to whether I would be allowed to use transcripts and video for different purposes. The level of authorisation will be reflected in the fact that whether I can use picture frames in this

thesis or only description of bodily aspects of talk. The six levels had to be signed off individually and were as follows:

1. Extracts from **video recordings** and **transcripts** can be used in research workshops with presence of principal investigator.
2. Extracts from **video recordings** can be used for educational purposes (undergraduate, postgraduate and continuous education).
3. **Transcripts** can be used for educational purposes (undergraduate, postgraduate and continuing education).
4. Extracts of **video recordings** can be used for scientific presentations.
5. **Transcripts** can be used for scientific presentations.
6. **Transcripts** or frames can be used for scientific articles.

As the specific consent form shows, video recordings require important considerations of participants' protection and necessary steps need to be taken. There are four critical moments where ethical issues are essential:

1. At the time when making the video tape
   In my study, consent was given at the beginning of physiotherapy treatment series and confirmed orally at the beginning of each of the sessions
2. At the time of analysing it (e.g. workshop)
   Data use for workshops was only possible with specific release for this purpose. I was responsible for the designation of data.
3. At the time of scientific presentations (including publication)
   Specific release had to be given by all participants for this purpose. As non-verbal communication is a very important part of physiotherapy, disguising images, such as by inserting a black bar over the eyes might decrease the value of the data. Where appropriate and with the permission from publishers, scientific publications could include drawings instead of still photos in order to reproduce the situation and context.
   According to the conditions set by the Ethics committee, it is required to use USB

sticks in order to limit the possibility that video clips could be released into cyberspace.

4. At the time when the video is used for non-research activities (e.g. educational intervention for staff or students)

   This use of the data is only possible with specific release from the participants. During educational activities, I reminded students/professionals about confidentiality (professional ethics).

When patients made their first appointment, the secretary asked if they would consider participating in the study. A flowchart (Appendix C) provides detailed information about how the process of recruitment of participants took place and how video recordings were organised. If the patient's response for participation was positive, a first appointment was scheduled for the initial consultation. At this point, I was able to give the patient additional information about the study. The patient had the right to leave the study at any time with no consequences. Informed consent from physiotherapists was sought at the start of the study and orally confirmed periodically. Physiotherapists and patients were also invited to watch the video recordings at any time and to decide whether all or parts of the recordings should be deleted. This option was never used by either group of participants. However, workshops with physiotherapists were scheduled at the end of the study to reflect on preliminary findings. I will come back to this later on.

3.5.4. Data collection, transcription and analysis

3.5.4.1. Data collection

The use of video recordings of work and interaction is an emerging field. Heath, Hindmarsh and Luff (2010) claim that video recordings augmented by fieldwork "enable researchers to address a range of phenomena, topics and issues that previously remained largely unexplicated" (p. 8). The authors add that video-based workplace studies are particularly interesting to a researcher who wants to "reconsider key concepts concerning the social organisation of work (p. 8). Parry (2010) also shows the

increasing importance of video-recordings in interactional research in healthcare. Apart from talk, bodily aspects of communication can be analysed in a context where delicate situations must be managed.

Prior preparatory fieldwork is recommended so that the researcher can get acquainted with the environment and the rooms where the filming will take place (Jordan and Henderson, 1995). While gaining access in my case was not a challenge (participating partner institutions were easily established due to personal acquaintances with the physiotherapists in charge), trust from participants has to be earned. Information on all participants is key to success, and it is suggested by Health et al (2010) that a researcher discuss the following issues with the participants: a) advantages of recording for the analysis of activities; b) the importance of recording remaining as unobtrusive as practically possible; c) the fact that data will only be used for research and teaching (but this is dependent on the consent of participants); d) that copies will not be available for those outside the research team; and e) that in no circumstances will the data be broadcast, appear on the web or be used for commercial gain (Heath, Hindmarsh and Luff, 2010; p.17). This was also a concern raised by the Ethics Committee (see Section 3.5.3).

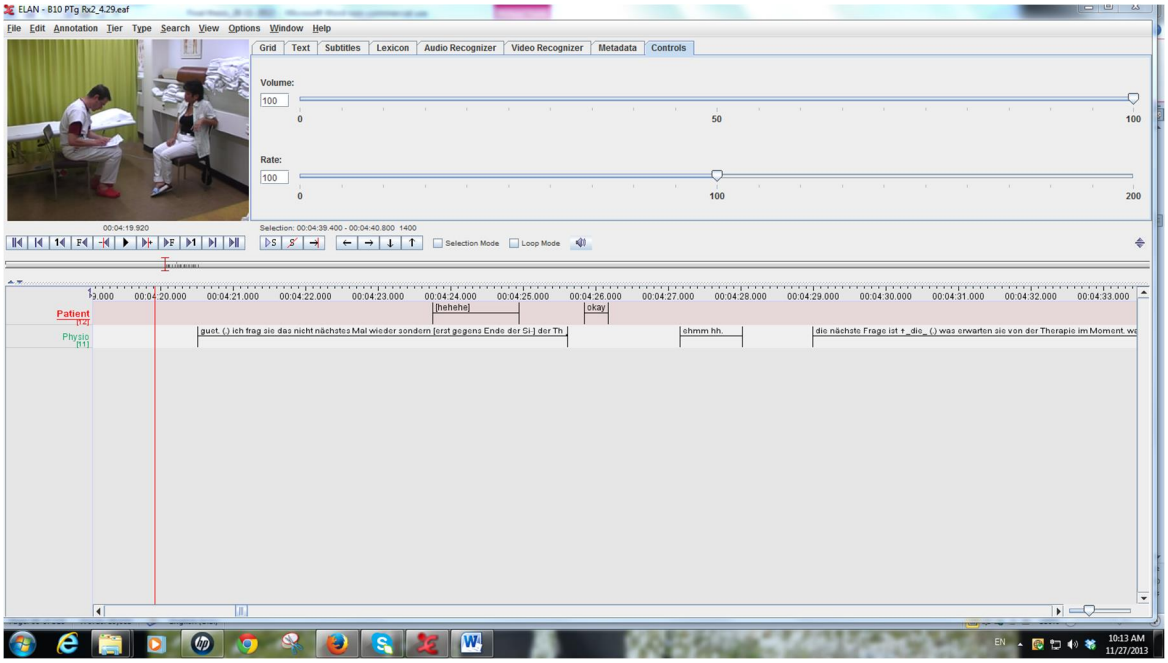
Video recording took place during the patient's initial assessment (first consultations) as well as on two follow-up treatment sessions. As physiotherapists tend to move around and change location depending on procedures performed, I decided to stay in the treatment area and adjust the camera when needed. It can be argued that recording might disrupt the natural interaction. Even though, initially, the camera was sometimes perceived as disturbing or even became a topic of conversation, the practices seem to be hardly affected by the presence of a camera (see Jordan and Henderson, 1995). One of the objections raised by critiques is that video recordings might influence the way participants 'normally' behave (Parry, 2010). Unfortunately, there is no way to investigate scientifically whether there is a difference of behaviour between "knowing to be observed" and "not knowing it" given the ethical concerns with regard to providing

information to participants. This dilemma is described as the 'Observer's Paradox' (Labov, 1972): it can never be known how the impact of the presence or absence of observation is (by using video-recording or other observational methods) without actually observing the situation. In addition to that, from an ethical standpoint, it is inconceivable that observations were done in a health care setting without prior information of all participants. Patients are considered 'vulnerable persons' who have the right to information as well as confidentiality from outside view. Those principles have to be respected under deontological guidelines and are protected by the ethics committee clearance of the project. Parry (2010) argues that any scientific enquiry uses various tool of investigation that might have an influence on the phenomenon under study. What I observed behind the camera is that whereas in the beginning of the consultations the camera was definitively not 'invisible' and sometimes also taken into consideration, the more participants were involved in their activity the less the camera was looked at. Overall, patients and professionals got easily accustomed to an unobtrusive camera in the corner. Additional wireless microphones for the physiotherapists were used in order to assure quality recordings. The quality of the recordings is important as it increases the reliability of the data (Peräkylä, 2004). In addition to this, being able to rely on the quality of the recordings enabled me to be more at a distance.

Being in the field also provides an invaluable source of information. My presence over a prolonged time gave me multiple occasions to discuss observations in an informal way. Not only is fieldwork useful for deciding where and how to film, but it also gives the researcher an opportunity to gain insights into documents, tools and technology used within the institution. Questions can be raised with regard to specific activities in which participants engage in, formal and informal division of labour in the setting, or routine patterns identified (Heath, Hindmarsh and Luff, 2010; p. 50). In addition to that, I also organised 'video review sessions' with professionals who participated in the study to talk to them and to play back video clips relevant to my research question. Even though I did

not use those sessions as data, they helped me get the professionals' views with regard to their practice.

The videos once collected were then kept on an external hard-drive and transferred to ELAN® Version 4.4.0. ELAN® is one of several programmes available for the analysis of videos using CA. It is free to use, and developed and housed at the Max-Plank-Institute in Nijmergen and has a good support system (website: http://tla.mpi.nl/tools/tla-tools/elan). This is what the system looks like:



In addition to the videos, I gathered some information regarding physiotherapists and patients that I kept separate to ensure confidentiality. This data was related to the therapists' experience, education and settings they have worked in. The patients' information concerned the diagnosis and age. Both patients' and physiotherapists' identity is concealed using ID numbers instead of their names when referred to in presentations and publications (see Appendix F).

3.5.4.2. Transcription

In general, there are different transcription conventions depending on what the transcript is needed for. It is essential to adapt the way data is transcribed to the purpose and the need for precision. If a transcript is used to analyse the *content* for a qualitative content analysis or a thematic analysis, it will certainly have less detail than if it is the intention to analyse *how* something is said, which is crucial information for discourse analysis or CA (Poland, 2000). Yet, even if a word-by-word or literal (verbatim) transcription is performed, every transcript is already an interpretation (Green et al, 1997). There is an inherent difference between spoken language and written words. People often talk in run-on-sentences, omit words or repeat them, are somewhat stammering or not pronouncing words clearly. Challenges of transcription are misunderstandings of words, mistaking words for other similar words, omissions of words by going forward and backward in the tape, or poor quality of tape recording (Buchholtz, 2007). It is argued that the "transcription process remains a time consuming, messy and an imperfect process that constructs a textual version of the original interaction" (Nikander, 2008, p. 226).

Conversation analysts use symbols to make the transcription more detailed and conventions exist in this field (Jefferson, 2004; Appendix D). In more general terms, transcription of talk allows the researcher to "come to grips with the details of the talk and the ways in which it emerges" (p. 19) as Health and Hindmarsh (2002) put it. Transcripts are never considered "data" (ten Have, 1999) because the recordings remain the primary data, but are used to explore particular features of the interaction, to capture phenomena of interest (ten Have, 1999) and to communicate findings (Arminen, 2005). There exists a number of transcription conventions, however the Jefferson's convention is the one most commonly applied to the transcription of CA data (Ten Have, 1999).

The data were recorded in Swiss German; however, the transcription was also translated to English in order to benefit from the network of experienced CA researchers and to make this work 'publishable'. The spoken words were translated according to ten

Have's (1999) suggestion: original transcript and a line-by-line translation. Jenks (2012) suggests performing three-line-translations with the first line in the original language (Swiss German), the second a word-by-word translation into English and the third line an idiomatic English translation. A three-line translation is the most inclusive way of presenting not only content, but also "word order, semantic and grammatical detail" with regard to the original (Nikander, 2008, p. 228). Yet, translating one language into another is not a straightforward process. There are decisions to be taken with regard to the details of transcriptions as well as to their printed presentation (Nikander, 2008).

The choices I had to make when transcribing my data and preparing the transcripts were related to a) what to do if the second and third line are identical; b) how to write what I hear; c) how to translate modal particles; and d) how to present bodily aspects of communication during the interaction.

a) Second line and third line are identical

I show below two extracts (3.3 and 3.4): the first extract is a three-line translation, the most common way of presenting my data, and the second extract is an example where the second and the third line is identical and therefore I present the transcript as a two-line transcript.

Extract 3.3: B19 PTb Rx1_5.56

1 Physio Was wär s'Ziel de jetzt vudere (.) Therapie[phase no einisch]
What would be the goal then now of this (.) therapy [phase once again]
What would be the goal for now for this therapy phase this time

2 Patient [He jo ↑stabili]siere (.)
[He PART to ↑stabili]se (.)
He *jo* to stabilise

3 m[eh gi]t- meh liet jo nümm din[ne]
m[ore is-] more lies PART not any more in [it]
more there is- there is *jo* not much more possible

When the first and the second line were identical, reading is facilitated by omitting the second line. This would be the case in the following example (line 13, line 16):

Extract 3.4: PTd Rx1_6.58

13 Physio	e::::hm (.) J:a und was isch dis Ziel?
	e::::hm (.) Ye:s and what is your goal?
14	**(0.5)** ***((****Physiotherapist looks at patient))*
15 Patient	Mis Ziel isch dass ich wieder cha go jogge so wienich körperlich au ↑mag
	My goal is that I again can go to jog like the way I physically also ↑be able
	My goal is that I can go running again as much as I am physically able to
16 Physio	**↑Mh[m]** ***((****Physiotherapist writes in chart))*
17 Patient	[o]hni dass mi de Schmerz behinderet
	[wi]thout that me the pain handicapped
	without being hindered by the pain

b) How to write what I hear

The challenge of transcribing was not only related to the accurate description of tone, speed and emphasis, but was also related to the difficulty with the translation. First of all, Swiss German is not a written language, meaning that there are no rules and conventions as to how to one has to write down what is heard; second, there are many different dialects pronouncing words differently. An example could be "*dass ich wieder cha go jogge*" (Extract 3.2, line 15 – third-line: "*that I can go running again*"). "*Ich*" (in English "*I*") can be pronounced as "*ig*" (Bernese dialect) or "*ech*" (Lucerne dialect) or can also be connected to the "*that*" culminating into "*dassi*". The presentation of the Swiss German version is mostly based on my dialect, which originates in the Central part of Switzerland. I argue that my presentation of the dialect is sufficient with the level of linguistic details brought forward in the analysis.

c) How to translate modal particles

There are many modal particles in Swiss German that are not translatable and that have been subject to little linguistic investigation, either in Swiss German or in German. There are particles such as "*jo*", "*ebe*" or "*eifach*". For example, the particle "*jo*" is etymologically related to the German "*ja*" but with a different function in this context. My lay sense would translate it as "*well*", yet this might not correspond to the equivalence of "*well*" described in the English papers (Schegloff and Lerner, 2009). In order to resolve this problem, while waiting for further linguistic studies, I decided to mark the modal particles "*jo*" and "*ebe*" as 'PART' in the second line, and "*eifach*" as 'MOD' as they are sometimes positioned one after the other and I wanted to show this difference. In the third line I keep the original word in Swiss German without translation, but present it in italic to make the non-English word visible. In cases, in which the particle did not provide any additional information to the meaning, I omitted it in the third line translation. I use footnotes to translate the words approximately.

In Extract 3.5. we have an example of "*jo*" (line 8), a particle abbreviated as PART followed by "*eifacht*", presented as MOD.

Extract 3.5. B03 PTc Rx1_22.34

6 Physio Eues Ziel oder eui Erwartig

Your goal or your expectation

7 (1.7)

8 Patient ↓Jo isch eifacht (.) dass i im Prinzip weiss (.) was i de au selber cha ↑mache [oder]

↓PART is MOD (.) that I in principle know (.) what I then also myself can ↑do [can't I]

***Jo* it is *eifacht* that I know in principle what I can do by myself as well can't I**

9 Physio **[↑Mhm]**

While I insert all prosodic features in the first and second line, the third line has only minimal representation of prosodic aspects of the talk in order not to disrupt the flow of the reading.

d) How to present bodily aspects of communication

The other question is how to present bodily aspects of communication. I decided to use a description of what is happening in brackets (mainly during pauses when therapists are writing, see Extract 3.4. line 14 and 16). When there were important indications of gaze or posture to be given, I used pictures to illustrate it. However, given the restriction of the use for images (see Section 3.5.3. Ethical aspects), I only use picture grabs in one example in which I show the importance of gaze for topic shifts (see Chapter 4). In addition, my study focus was on therapists' enquiry about goal setting and how patients respond to those enquiries, and it relies, therefore, mainly on vocal features of talk. However, having video data as primary data still allows for detailed analysis of bodily movements.

3.5.4.3. Data analysis

Seventy-four sessions (about 50 hours in total) were watched and episodes relevant to the research questions were selected. I was interested in finding episodes in which goals are discussed or referred to. I was particularly interested how therapists topicalise goals. The selected episodes were transcribed and analysed using the conversation analytic approach described by Heritage (2005) and Ten Have (1999).

The purpose of the analysis is to find patterns and explicate their logic (ten Have, 1999).There is no categorisation of data in advance. The same terms can have different interactional functions, and the richness of the data would be limited if categories were made up in advance (Drew, 2005).

The first phase is called 'unmotivated looking', meaning that it was not "prompted by pre-specified analytic goals" (Schegloff, 1996 cited in ten Have, 1999, p.103). The idea is that the observer has an "open-minded attitude to the data" (ten Have, 1999, p.104), and can be compared to the approach of "bracketing" in phenomenological studies (ten Have, 2006). In line with EM, this temporary suspension of the "privileged version of the social world" is also called "ethnomethodological

indifference" (Holstein and Gubrium, 2005; p. 486). As I was interested in goal setting, I was looking for occasions where goal setting was happening.

Once an interesting phenomenon in one case has been detected, the data corpus will be searched for other instances of the same phenomenon (Arminen, 2005). I started out with four cases I considered interesting with regard to the way therapists initiated the goal enquiry, the length of the discussion, or how patients participated in this exchange. I watched the 12 videos in details (all three recorded consultations for four cases), making observations, and selected sequences related to goal setting in B03, B11, B12, and B18 (see Appendix E as example). I determined where I wanted to put the focus and those case studies served as test to circumscribe the phenomenon. I realised that there was very often an explicit enquiry by therapists with a question of the "*what is your goal?*" or "*what do you expect from physiotherapy?*" type. I decided to collect all episodes (in all 28 cases) in which this explicit enquiry took place.

In order to enhance validity of my claims, emphasis was also put on locating and analysing deviant cases (Peräkylä, 2004). These discrepant cases force us to pay particular attention to the sequence. At this point, comparison between the observed phenomenon in the institutional setting and ordinary conversation might increase the understanding. With recorded video data, repeated scrutiny might provide additional insight into "resources, practices, procedures and reasoning on which participants themselves rely in accomplishing particular actions and in making sense of the contributions of others" (Heath, Luff and Sanchez Svensson, 2007, p. 111).

In order to refine the initial analysis, discussions and data workshops with other CA researchers are part of the established practice in the field. This approach enhances the quality and usefulness of transcribed data. The purpose of the workshops is related to the nature of interaction analysis. Jordan and Henderson (1995) argue that "interaction analysis is difficult to describe and is best learned by doing" (p. 43). Collaborative viewing helped also neutralise certain of my preconceived notions of rehabilitation interaction related to my being a physiotherapist by training (Jordan and

Henderson, 1995). Those data analysis sessions can also increase the understanding of the phenomenon observed and its possible meanings (Parry, 2010).

The final phase of analysis, in which the cases are grouped and thereby phenomena outlined, makes the final step of producing a pattern (Arminen, 2005). Once I decided to focus on the explicit enquiry of goals by therapists, my analysis in this thesis was divided into three parts: Chapter 4 on questions posed by therapists; Chapter 5 on responses given by patients; and Chapter 6 on how those initial responses are followed-up.

3.6. Conclusion

In this chapter I have presented the theoretical aspects of my study methodology and elaborated on the different philosophical underpinnings for interactional research. I provided insight into how CA was developed by drawing on both Goffman's theory of interactional order and Garfinkel's Ethnomethodolgy. The connection between Goffman, Garfinkel and Sacks was strong on theoretical grounds, and they were mutually influencing each other. I have shown that CA is an appropriate method for investigation of the phenomenon under scrutiny. The reasons for this include the fact that CA provides tools such as the analysis of turn-taking, sequence organisation and the overall sequence structure which can shed light on patterns of communicative practices and the use of resources to make sense of the other's action. I have argued that quantitative methods are insufficient for describing interactions between patient and physiotherapist in detail, in particular with regard to the analysis of interactivity, and qualitative methods such as ethnography or phenomenology do not use the tools of video-recordings, which offer the possibility of repeated scrutiny and the inclusion of analysis of bodily (non-vocal) resources during real interactions in professional practice. CA clearly has advantages for my research purposes and has the ability to shed light on tacit practices.

The presentation of the empirical aspects of my study included a description of how I set up and undertook the specific phases of this conversation analytic investigation. The detailed presentation of study design, study sites, participants,

methodological and analytical steps provide sufficient transparency to know how I arrived at my findings. The next three chapters present the key findings of this study.

Chapter 4: Physiotherapists' enquiry about goals

4.1. Introduction

In previous chapters, I presented goal-setting theories, as well as studies investigating the application of those theories to health care in general, as well as physiotherapy in particular. The theories are supported to varying degrees by evidence; however, little in-depth analysis of the ways in which physiotherapists and patients discuss goals has been performed.

In this chapter, I show how physiotherapists ask questions that topicalise treatment goals. I analyse when and how therapists initiate a goal enquiry by presenting first the structure of initial assessment consultations. I describe the question formats used in goal enquiries, explaining their interactional features. The majority of questions (11/15) posed by therapists are *wh*-questions like "*what do you expect from physiotherapy?*" or "*what would you like to achieve?*" or an abbreviated version of *wh*-questions (3/15). Only in one episode, does the therapist ask the patient about goals by using a different question design ("*Do you have a certain goal in mind?*").

Questions can be differentiated by their format (e.g. *wh*-question, Yes/No-Interrogative – see Section 4.1.3.1), but they can also be characterised according to different dimensions of question design (e.g. agenda-setting – see Section 4.1.3.2). One of four dimensions described by Heritage and Clayman (2010) is the embedding of assumptions or presuppositions in therapists' questions when they enquire about goals. Two common assumptions are (1) that patients have a goal, and (2) that they are willing and able to articulate that goal. Those assumptions are enacted through the way physiotherapists introduce the goal enquiry and are sometimes collaboratively oriented to by both participants. Yet, it is evident that interactional difficulties arise when participants do not appear to share those assumptions. I support this argument by showing evidence from several goal setting episodes.

Finally, I demonstrate that therapists treat goals as standalone items that a patient is expected to have in mind. Therapists convey goals as specific ideas or desires in the domain of the patient that exist prior to any question being asked about those goals. Yet, my data clearly illustrate that goals are often mutually constructed entities and not – as policy papers and teaching handbooks suggest – entities that exist independently within patients' minds and in advance of the asking of a questin about those goals. Problems arise as a result of tensions between therapists' apparent conceptualisation of goal setting (including their assumptions) and patients' demonstrated understanding and knowledge about goals and/or physiotherapy. Therapists use different interactional resources, such as pursuit of response as well as accounting[7] for their questions, to manoeuver through the goal setting process. I argue that goals are collaboratively set and that assumptions embedded in therapists' goal enquiry might cause problems if those assumptions are not shared, aligned with, and understood by patients.

Before presenting the findings, I provide a review of the literature on topic shifts in conversation, because this is relevant for how goal setting is initiated, and I overview existing conversation analytic literature on questions, including on the structure and functioning of questions in medicine. By summarising these literatures, I describe specific features of topic shifts and question formats.

4.1.2. Topic shift

Topic shifts are important as they structure the phases in the information-gathering phase in health care interactions (Campion and Langdon, 2004). Although there is debate about whether 'topic' is the correct term, it is the one often used in the context of health care interactions (Sidnell, 2010; Ariss, 2009; Hudak and Maynard, 2011). It is argued that the term tends to be problematic because a 'topic' could be a sentence, a stretch of a sentence, or something else (Schegloff, 1990) and that the practices of topic-shading (Schegloff and Sacks, 1973) and step-wise transition (Jefferson, 1984) make the definition of a 'topic' complicated. Therefore, Schegloff (1990) favours

[7] The term 'account' is defined in the Conversation Analysic literature as follows: "a linguistic device employed whenever an action is subjected to valuative inquiry" (Scott and Lyman, 1968, p. 46).

'action' instead of 'topic' in order to avoid falling into the trap of "talking about" instead of analysing the "talk-that-does" (p. 52). Using the term 'action' indicates that participants themselves orient to their interaction in terms of actions and not topics. Nevertheless, in recent textbooks (Sidnell, 2010) as well as in previously mentioned studies, 'topic' has been treated as a term describing talk-in-interaction. Whereas Schegloff (1990) argues that topics are not clearly distinguishable, Sidnell (2010) claims that "it should be possible to locate a set of practices in conversation by which topics are generated, maintained, pursued" and "through which respect for topic is displayed" (p. 226). Following Sidnell's argument and in view of my own data I consider goal setting a stand-alone topic, and I show that it is treated as such in the interactions.

Topic shifts are accomplished through both vocal as well as bodily actions. Participants can close down a prior sequence by doing it in a step-wise manner (Jefferson, 1984) or by using resources such as "sequence closing thirds" (Schegloff, 2007a), which is the case in my data. While Beach (1993) found, in an English-speaking environment, that "*okay*" is used to prepare a closing, the associated declining volume and pitch also indicate closing (Schegloff, 2007a). Apart from vocal resources to shift to a new topic, Robinson and Stivers (2001) showed that transitions from the history-taking phase to the physical examination are achieved with embodied action, such as body movements and gaze. This is in line with Heath's (1986) ground-breaking research which shows the importance of body posture and movements in medical interactions.

While body movements and postures, as well as gaze have to be considered valuable resources for goal setting, it is the question about goals that is the main focus of this chapter. Let's turn now to the literature on question designs and function in conversations.

4.1.3. Questions and their function in interaction

While questions are omnipresent in interactions, they are not so easily defined. Questions "solicit information, confirmation or action and are delivered in such a way as to create a slot for the recipient to produce a responsive turn" (Ehrlich and Freed, 2010;

p.6). The basic structure of a question-answer sequence is the adjacency pair (Schegloff, 2007a – see Section 3.4.4). Adjacency pairs are crucial for understanding the organisation of talk-in-interaction as the participant's answer to a next turn "displays their speaker's understanding of the just-prior turn" (p. 15).

The conversation analytic literature explores the different nature of questions in terms of formats, as well as dimensions inherent to questions that shape the interaction between participants, in both the institutional context or in mundane conversations.

4.1.3.1. Question formats

Three question formats are differentiated in the literature: (a) Yes/No Interrogatives or YNIs (also referred to as polar questions), (b) *wh*-questions, which are questions using words such as 'what', 'why', 'when', 'who', 'where' and 'how', and (c) alternative questions (Stivers, 2010; Stivers and Enfield, 2010).

(a) YNIs are designed to encourage Yes or No responses and have three subtypes: (a) interrogative (i.e. subject/auxiliary inversion), (b) declarative (no formal interrogative marking), and (c) tag-question (e.g. isn't it?). In the context of medicine, YNIs are frequent (Heritage, 2010). Typically, routine questions in medical interactions take the YNI format, and are usually brief; in particular those checklist-style questions that expect brief "no problem" responses from the patients (Boyd and Heritage, 2006, p. 171). Here is an example from my data:

Yes/No Interrogative: B09 PTe Rx1 20.06 (simplified transcript)

1 Physio	.hhh Did uh:m Doctor D say what you are not allowed to do. (.)
2	at the mome[nt.]
3 Patient	[He] just told me not to push it huh

The YNIs have a double function: on the one hand they acknowledge the epistemic rights of respondents (patients have sufficient knowledge to answer), while on the other hand they tend to restrict the exercise of those rights. This means that YNIs

exert pressure on the answerer to confirm or deny the proposition (Heritage and Raymond, 2012).

(b) *Wh*-questions are generally less frequent than YNIs (Stivers, 2010), but they are common in medical interactions, especially in the problem presentation phase (Heritage and Clayman, 2010). It is also the most common question type for the initiation of goal enquiry in my data:

Wh-question: G02 PTn Rx1_00.18 (simplified transcript)

9 Physio	And what is the goal.
10	(0.9)
11 Patient	That I can go back to work fully

Wh-questions have different actions, which can be divided in three categories:

1) doing information-seeking only;

2) ambiguity of doing information seeking while doing another activity such as challenging, inviting or requesting;

3) doing challenging only (Egbert and Vöge, 2008, p. 18).

The *wh*-questions in my data are treated mainly as information-seeking.

(c) The last type of questions – alternative questions - is not as common in conversations (Stivers, 2010). These questions force a choice upon the recipient by linking two separate questions as "either – or". Here is an example from my data:

Alternative questions: B19 PTb Rx1_5.55 (simplified transcript)

23 Patient	Just that- if I do something uncontrolled at a machine and- do like a stupid movement
24	this (.) happens just sometimes [doesn't it?]
25 Physio	[While] standing or is it when crouched down at the floor
26	(0.8)
27 Patient	Well I cannot crouch properly anymore so[mehow] (.) so I have already (.) today (.)
28 Physio	[Yes]
29 Patient	when I (.) have to put the shoe- well now to put in the buckle [I have trouble]
30 Physio	[Yes]

My data on goal setting sequences relies mainly on *wh*-questions. Apart from the question design, there are four dimensions determining the function of questions in medical interactions, which I briefly review here.

4.1.3.2. Dimensions of questions

Questions do not function only as information gathering devices but are also resources for embodying presuppositions (or assumptions, which are the focus of this chapter), conveying epistemic stance, incorporating preferences, and setting topical and action agendas (Heritage, 2010). It has been argued that there are no neutral questions and that "all questions embody presuppositions about the state of affairs to which they are directed" (Heritage and Clayman, 2010, p. 139).

Presuppositions - assumptions

Assumptions can be embedded in questions without making those assumptions explicit. This is the case in various institutional interactions such as health care interactions or news interviews (Heritage and Clayman, 2010). Heritage and Clayman (2010) give examples from medical interactions of questions that semantically presuppose that the patient uses contraceptives and imply also some assumptions in regards to heterosexuality, as well as to the capacity, but not the desire, to bear children.

(1) [Heritage and Clayman 2010: 139]

1 Doc: What kind of contraception do you use?
2 Pat: None, since my menopause.

Notably, line 2 shows that some of these presumptions are incorrect.

In the next extract, the physician produces two questions, with the second addressing the assumptions that underlie the first:

(2) [Heritage and Clayman 2010: 139]

1 Doc: Are you using any contraception? Is that
2 necessary [for you?
3 Pat: [Huh uh (not now.)
4 Doc: °(Okay.)°

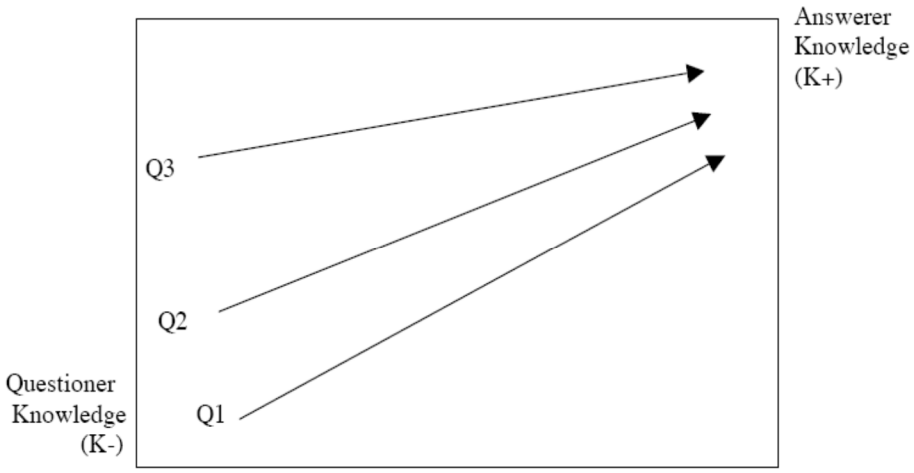
While the first example embeds the assumption about contraception use implicitly, the second example shows how the physician is addressing explicitly the underlying assumptions.

Presuppositions embedded in questions can be unproblematic (Hayano, 2013) and can be shared or not by participants, which I demonstrate in my finding section.

Epistemic stance

The term epistemic stance refers to to the questioner's level of knowledge (see Figure 4.1 below, Heritage and Clayman, 2010). Three levels are differentiated, from the unknowing questioner (Q1 – content question), to a more knowledgeable questioner (Q2 – interrogative question), to an informed questioner (Q3 – tag question).

Figure 4.1: Question designs and epistemic gradient (Heritage and Clayman, 2010, p. 140)



Hayano (2013) gives three examples to exemplify Q1, Q2 and Q3:

(3) [Hayano 2013:399]

Q1) Content question:	Who were you talking to?
Q2) Interrogative question:	Were you talking to Steve?
Q3) Tag question:	You were talking to Steve, weren't you?

Those three questions result in a different epistemic gradient, from a shallow to a steep gradient. To understand epistemics in question designs is important for my data, and I come back to it in more detail in Chapter 5.

Preferences

When the term preference is used in a conversation analytic approach, it refers to the bias or tilt of questions that suggest an expectation of a particular answer (Heritage and Clayman, 2010). The core idea of preference is that participants follow certain principles to avoid or minimise disagreement or rejection (Pomerantz and Heritage, 2013). Speakers orient to their co-participants in a relevant manner by tailoring the talk to the recipient (recipient-design) or, in case of recipients' hesitation, by anticipating those delayed responses with "talk that changes the options for responding" (Pomerantz and Heritage, 2013, p. 216). Yet, most of the work on preference organisation concerns YNIs. Through examples of not-so-straightforward responses to goal enquiries found in my data, I provide some insight into circumstances in which conflicting preference principles exist. These so-called dispreferred turns demonstrate how patients manage the pressure to provide a goal (which they might not feel capable of producing) and the pressure to respond to the question posed to them. I attempt a more detailed description of competing preference principles in Chapter 5.

Setting agendas

Analysis from medical interactions detected two different aspects of setting an agenda: questions set both the action agenda and the topical agenda (Heritage, 2010). The topical agenda refers to the "topical domain raised by a question" (Clayman, 2013, p. 641), i.e. what additional information the questioner would like to receive. The action embedded in the *wh*-question refers to the need for the answerer to provide "statements of who, what, when, and so on" (Clayman, 2013, p. 641) thereby addressing the action asked for. The way an agenda is set makes us understand how both patients and physicians (in medical interactions) collaborate to understand the other's concern. Although agenda-setting is also interesting for physiotherapy consultations, this dimension of questions will not be considered in detail in this chapter.

For this chapter, the understanding that assumptions and preferences are embedded in questions is highly relevant. My analysis will show that physiotherapists embed those dimensions into their goal questions. I will also show that a patient sometimes collaborates with the physiotherapist and goes along while, at other times, a patient and the physiotherapist do not mutually orient to those assumptions and preferences.

4.2. Findings

For this chapter, I have selected cases in which physiotherapists ask questions about goals. I found that physiotherapists solicit treatment goals from patients by using direct *wh*-questions such as "*What is your goal?*", "*What do you expect from physiotherapy?*" or "*What would you like to achieve?*". I analyse the cases in regards to question formats and prosodic features and how those elements of interaction function in a physiotherapy context.

Section 4.2.1 presents the phase structure during assessment consultations, usually the first consultation when patients seek physiotherapy services. Understanding this is important because a discussion about goals in the beginning of an encounter cannot rely on the same information as such discussions later in the consultation, or in subsequent consultations. I also show not only when, but also how goal enquiry is oriented to as a topic in its own right. This is clear in the interactional features the sequence entails.

In Section 4.2.2 I examine three types of questions used by physiotherapists when they enquire about goals: *wh*-questions, abbreviated *wh*-questions, or Yes/No interrogatives (YNIs). The latter question type, as it is a single case, I only touch on briefly. I analyse the question format and its characteristics during what we might call interactionally smooth goal discussions. I focus on practices in which patients' initial responses regarding goals are collaboratively reformulated and culminate in goals that are treated as acceptable for physiotherapy. These practices maintain the assumption that patients have a goal. I show how therapists embed this assumption in their question

format. A second assumption – that patients are able to articulate a goal – is conveyed by the straightforward posing of goal questions. Furthermore, I demonstrate that abbreviated questions maintain the same assumptions.

The analysis of six less-than-straightforward cases (Section 4.2.3) provides insight into interactions that do not align with those assumptions. I give examples of interactions in which patients respond in non-straightforward ways, thereby demonstrating that they do not share the assumptions underpinning the therapist's question or they do not have the knowledge required to answer the question. Interactional resources such as counters and insert expansions (Schegloff, 2007a) are used by patients, and these limit the progressivity of the sequence. One interactionally problematic case shows how the physiotherapist accounts for her action (enquiring about goals) by making the reason for the goal-setting process explicit. This interaction illustrates the complex nature of goal-setting and the effort participants may have to put in to achieve goal setting.

In the subsequent discussion, I examine the implications of the findings in terms of conceptualisation of goal setting, with regard to question design and the dimensions of questions. The discussion puts the results in the context of current literature from other settings. I demonstrate that my findings contribute to the understanding of the complexity of goal-setting. A reflection on those findings completes the discussion.

4.2.1. Phase structure of physiotherapy assessment

The analysis of my data presented in this section focuses on when and how therapists elicit patients' opinion about goals. In the physiotherapy literature, the phase structure is described in three parts: introduction, main part, and closing (Elzer, 2009). In this textbook on competencies in physiotherapy communication, the introductory part of an assessment includes an introduction, greetings, a presentation of purpose and the offer of a seat on a chair or a bed. The second phase includes the history-taking phase, the physical examination, an invitation for questions, and the introduction of the closing phase. The last part is presented as the closing, which includes a summary of the

consultation, a plan for future, and farewells (Elzer, 2009; p. 190-191). Whether this prescription is followed in practice will be the subject of this section.

The interactions I analyse in this chapter stem from 15 episodes (out of a total of 28 – see Appendix G) in which physiotherapists topicalise patients' goals by posing questions. The flow chart on page 13 presents the different phases. In the majority of cases the direct question is posed during the information-gathering phase (alongside enquiry about occupation, leisure activities, etc. – in **4 out of 15** cases) or just before the physiotherapist performs the physical examination procedures (**8/15**). In two cases (**2/15**) the enquiry takes place during intervention procedures (mobilising knee joint in the first consultation, mobilising shoulder joint in the second consultation), and one physiotherapist solicits goals in the beginning of the second consultation (**1/15**).

Examining the 15 episodes, the phase structure of initial consultations can be summarised in a list. Even though not all points are discussed in all interactions, most of them were. In *italics* I describe the specific cases, sometimes specifying the reasons for omission. The number in brackets indicates when topics were discussed.

1. **Greetings**: Physiotherapist indicates where to go/ sit down

   This phase sometimes also includes discussion about the study and filling out the informed consent form **(15/15)**
2. **Therapist's explanation of what is going to happen** in this and subsequent consultations

   This is done in all consultations of the hospital-based outpatient clinic but *not in private practice settings* **(13/15)**
3. **Questions regarding physician's referral** (patients bring referral letter with them):

   In three cases this is not done **(12/15)**
4. **Therapist's information-gathering** (all points are discussed unless otherwise stated):
   a) Exploring patient's problems using questions such as: "*What is your main problem?*" **(15/15)**
   b) History: When and how did the problem start? **(15/15)**

c) Description of problem/pain and its implication for daily activities **(15/15)**

d) Occupation

This is *not discussed in two consultations*, one with an elderly woman (retired) and the other with the patient returning for a second series of physiotherapy treatment with the same therapist **(13/15)**

e) Leisure activities

Not discussed in 5/15 cases **(10/15)**

f) Goals **(15/15)**

g) General health status **(15/15)**

h) Previous physiotherapy treatment **(15/15)**

i) Medication **(15/15)**, medical exams **(9/15)**

The question about medication is asked in all consultations (apart from one case where there is a detailed medical report in the physiotherapist's hand), the *questions regarding medical exams are not discussed in 6 interactions*

j) Social context (living arrangements, help at home, children, etc.)

Discussion takes place only in 6 cases **(6/15)**

5. **Introduction of physical examination procedures** (sometimes preceded by therapist's summary of information received from the patient)

This is *done in 13/15 interactions*. In two cases the physiotherapist postpones physical examination procedures and starts treatment (exercise corrections) **(13/15)**

6. **Physical examination procedures (13/15)**:

a) Mobility, flexibility, and strength tests

b) Additional testing if considered necessary by the physiotherapist (neurological test, balance test, etc.)

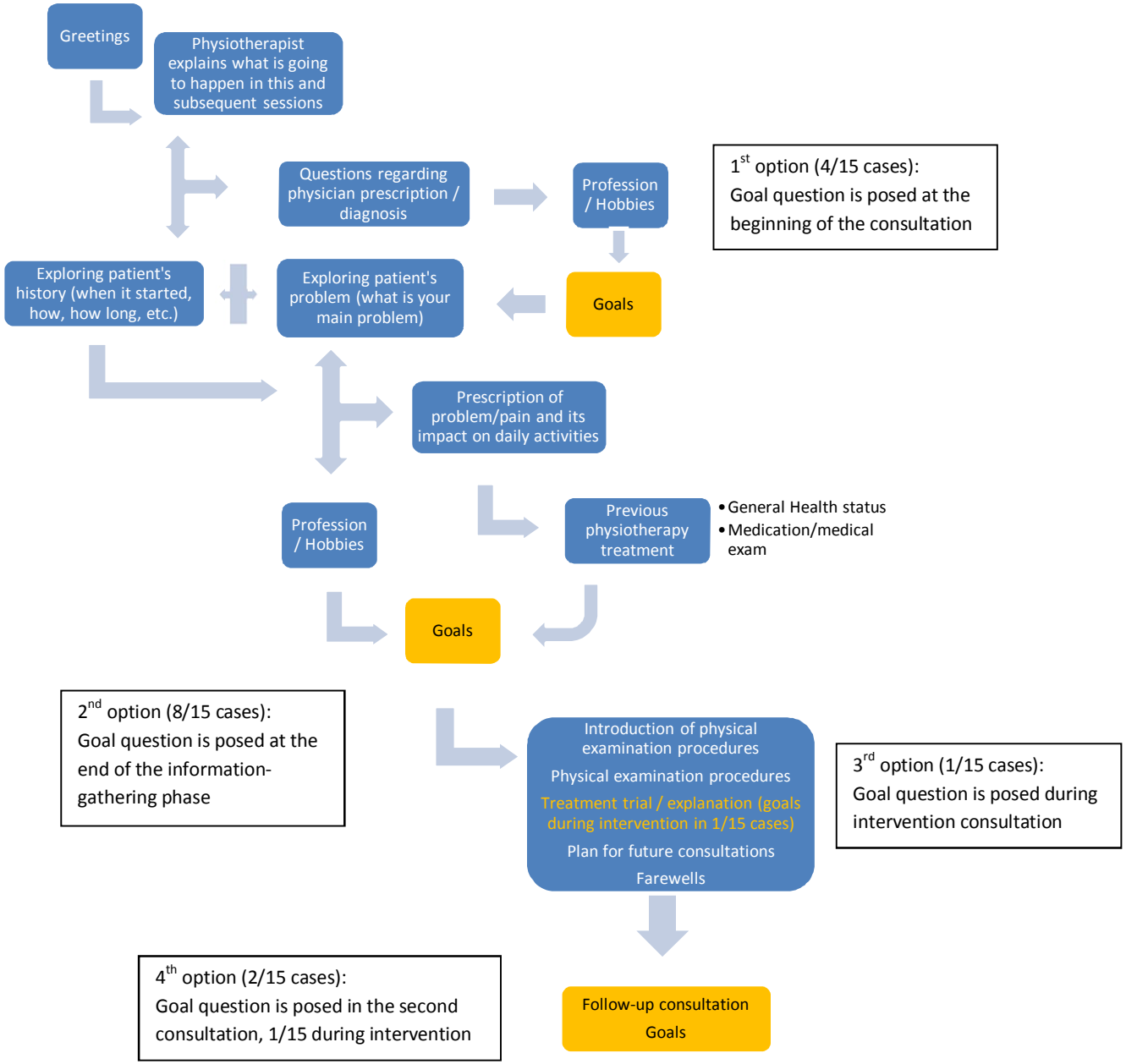
7. **Treatment trial and/or explanation**, including advice giving and instructions (e.g. exercises) **(15/15)**

8. **Plan for future consultations** (**14/15 cases** preceded by a summary of examination results)
9. **Farewells (15/15)**

The most variation is visible in **phase 4**: therapists sometimes initiate this phase with point 4d) including questions regarding goals or previous treatments, whereas others start with 4a) – c) before entering 4d) or other topics. Fewer discussions take place in regards to hobbies (4e), medical exams (4i) and social context (4j).

The flowchart (Figure 4.2) below presents the four different moments of goal enquiry. Most often, goals are discussed either in the beginning of the information-gathering phase (4/15) or at the end of the information-gathering phase (8/15), while in few cases goals are discussed during an intervention (1/15) or during the second consultation (2/15).

Figure 4.2: Flow chart for cases included in this chapter



My data indicate that the first assessment consultation is quite structured and that similar topics are covered in the initial assessment session. However, in order to understand not only in what order activities of consultations are organised, but also to analyse how this is done, I now present the interactional features of shifting the topic to the goal enquiry.

Topic shifts are frequent in health care interactions and have been analysed in different contexts (see Section 4.1.2). The most common way for physiotherapists in my data to initiate the goal enquiry is to close down the previous discussion. In the majority of the cases, the physiotherapist clearly marks the end of prior discussions (13/15) and introduces the goal enquiry as a new and standalone action. By doing so, the physiotherapist conveys the message that goal enquiries are independent from other topics, and that the patient has sufficient prior knowledge to respond to this question. Goals are treated as separate entities and not necessarily constructed through interaction.

In the first Extract 4.1 the physiotherapist closes down the prior sequence (discussion about activities the patient would like to improve) and introduces the goal enquiry as a new topic.

Extract 4.1 : B10 PTg Rx2_4.22[8]

1 Physio	Guet. (.) ich frag sie das nicht nächstes Mal wieder sondern [erst gegens Ende der Si-] der Therapie.
	Good. (.) I ask you this not next time again but [only towards the end of the se-] the therapy.
	Good. (.) I am not going to ask you this again until the end of the se- the therapy.
2 Patient	**[h e h e h e h e h e h e]**
3	(0.9) *((Physiotherapist turns away from patient, puts the chart on the bed and starts writing))*
4 Patient	Okay
	Okay
5	(1.0)

[8] **B10:** Code Patient – **PTg:** Code Physiotherapist – **Rx1:** first treatment session – **4.22:** point of time in consultation

6 Physio	Eh:::::m hh.	
	Uh::::m hh.	
7	(1.0)	
8 Physio	Die nächste Frage ist ↑die (.) was erwarten sie von der Therapie im Moment.	
	The next question is ↑this (.) what expect you from the therapy at the moment.	
	The next question is this one (.) what do you expect from therapy at this time	
9	was ist ihr Ziel. was möchten Sie erreichen.	
	was ist your goal. what would like you to achieve.	
	what is your goal. what would you like to achieve.	

The physiotherapist marks the adequate completion of the foregoing action with "*good*" (line 1) and "*okay*" (line 4). Line 1 can be described as "sequence closing thirds" (Schegloff, 2007a), a turn closing down the sequence without contributing to the progressivity of the talk. By adding in line 1 that the topic discussed will only come up again at the end of nine consultations (the number allowable in the Swiss health system), the therapist indicates the closure of this topic. A decreasing pitch at end of line 1 also contributes to the action of closing down the sequence (Schegloff, 2007a). The patient collaborates with the therapist by laughing (line 2) and an acknowledgment ("*okay*" - line 4). In addition to vocally closing down the topic, the therapist also indicates the end of the previous sequence with a shuffling of paper and a change in body position as well as the start of writing (line 3). Non-vocal actions are important in transition between sequences and phases in medical interactions (Robinson and Stivers, 2001). The physiotherapist opens the new topic with a "*uh:::::m*" followed by an in-breath (line 6). The physiotherapist produces the new sequence/topic explicitly by introducing the next question (line 8 – "*the next question is this*"), and vocally accompanying it with an increasing pitch (Schegloff, 2007a).

This first case exemplifies common characteristics of ending a prior sequence and introducing the goal enquiry. The therapist uses sequence-closing thirds with acknowledgment tokens ("*good*", "*okay*"), changes in pitch (decreasing at the end of the turn, increasing at the start of the new turn), in-breath to indicate the start of a new turn

and embodied actions (gaze shift, shuffling paper, writing). I will be able to point to similar features across my data.

Thus, physiotherapists and patients collaboratively close down the previous sequence before opening the goal enquiry. The next example shows how the physiotherapist treats the sequence in a similar way but the patient does not produce any further talk during the process of closing the prior sequence down. The patient consults the physiotherapist because of a broken tibia (fracture below the knee) after a fall. She wears a removable cast and has difficulty bending her knee. In the beginning of Extract 4.2 they are talking about the patient's leisure activities. The patient's husband is present during the consultation and participates in the discussion.

Extract 4.2: G05 PTk Rx1_13.36

1 Patient	Ich mache relativ viel (.) [süsch] mitem Hung go laufe tägl[ich] (.) süsch.
	I do relatively a lot (.) [othertimes] with the dog go walking dai[ly] (.) othertimes.
	I do quite a lot (.) othertimes I go walking with the dog daily othertimes.
	((*Patient looks at the chart while the physiotherapist is writing, then looks at window, then at husband))*
2 Physio	[Ja] [Ja]
	[Yes] **[Yes]**
3 Husband	Süsch
	Othertimes
4 Patient	**[hehehe]**
5 Physio	[hehehe] (.) Okay (.) guet.
	[hehehe] (.) Okay (.) good. *((Physiotherapist writes in his chart))*
6	(1.0)
7 Physio	Ehh- ↑mhm
	Uhh- ↑mhm *((Physiotherapist taps with pen on chart))*
8	(1.0)
9 Physio	Genau hh
	Exactly hh *((Physiotherapist turns his gaze to patient))*
10	De hani no en (.) letzte ↑Frag was- was erwarte (.) sie (.) vu de Physiothera↑pie
	Then have I still a (.) last ↑ques□on what- what expect (.) you (.) from the physiother↑apy
→	**Then I have just one last question what- what do you expect from physiotherapy?**

11	°was erwarte sie vu ↑<u>mir</u>
	°what expect you from ↑<u>me</u>°
	what do you expect from me?
12 Patient	°Ehm °
	°Uhm ° (*((patient looks away and down to her foot))*
13	(2.4)
14 Patient	Jo i wetti gern- aso i denke weni s'chneu denn würklich wieder chan mache das isch scho viel
	PART I would like- PART I think if I the knee then really again can make that is already a lot
	***Jo*[9] I would like- *also*[10] I think if I could bend the knee again that would already be a lot**

First of all, I highlight some similarities with Extract 4.1: The patient responds to the therapist's question with regard to her leisure activities (line 1). The physiotherapist writes down the patient's information. He is contributing minimally with talk (line 2 - acknowledging the patient's talk) but uses a bodily action (writing) to move the sequence forward. In line 5 the physiotherapist indicates that the sequence is coming to a close by first participating in shared laughter, and then using the tokens "*okay*" and "*good*" with a decreasing pitch. There is a collaborative pause in line 6 while the physiotherapist continues to write in his chart. In line 7 he produces an "*uhh-"* with an acknowledgment token ("*mhm*"). The rising intonation is treated as relevant to making a transition to the goal enquiry. At the end of this utterance (line 7) the therapist marks with the pen in an embodied way the completion of the turn. He then gives an assessment of the prior discussion (line 9), which could be described as a sequence-closing third (Schegloff, 2007a). The goal enquiry starts in line 10 when the physiotherapist asks the patient about her expectations with regard to physiotherapy.

Generally, physiotherapists in my data orient to goal-setting as a new topic separate from the previous one by referring vocally and in an embodied way to the end of the prior turn as well as to the beginning of the new sequence. This discovery – goal enquiry as a standalone activity - is important for the understanding of goal setting. Physiotherapists treat goals not as emerging from prior discussion with the patient, but as goals pre-existing in the patient's mind. In this sense, goals are topicalised in a way

[9] Approximate translation: "*yeah*" or "*well*"
[10] Approximate translation: "*well*" or "*thus*"

that is similar to the way medications or doctor's appointments are topicalised by other questions. I come back to this point in the following chapters when I analyse patients' initial responses (Chapter 5) and transformations of these responses (Chapter 6).

After having outlined the structure of physiotherapy consultations and the importance of topic shifts, I will now provide in Section 4.2.2 insights into the question formats and the assumptions embedded in those questions.

4.2.2. Physiotherapists' question about goals

Physiotherapists like any other health professional (e.g. physicians) require information in order to understand the patients' problem and propose a treatment addressing that problem. The focus of this section is to describe how therapists enquire about goals and what assumptions are embedded in the question. First, I show how physiotherapists initiate the enquiry and how patients respond to those questions. By focusing initially on those consultations that are interactionally 'smooth' I am able to discern how participants maintain these assumptions underlying the goal enquiry question: that patients have a goal and that patients are able to articulate it.

Question format

Physiotherapists use *wh*-questions in most cases of the subset of goal enquiring episodes (11/15), for instance *".hh Und was isch Eues ↑Ziel"* (**".hh And what is your ↑goal"** – B08 PTd Rx2_9.56). Less commonly (3/15), they pose versions of *wh*-questions in which the 'what is' component is elided, eg. *".hh (.) Und (.) Eues:: Zi:::el ↑jetzt oder Eui Erwartig ad ↑Physiotherapie?"* (**".hh (.) And (.) your:: go::al ↑now or your expectation for ↑physiotherapy?"** – B20 PTc Rx1_23.39). In one instance a YNI format was used: *"Heiter es bestimmts ↑Ziel? (.) vor ↑Auge?"* (**"Do you have a certain ↑goal? (.) in ↑mind?"** – B17 PTb Rx1_34.40).

The three question formats show common features across the examples:

- Physiotherapists ask the question about **one** goal, not several goals (see examples above)

- Physiotherapists enquire explicitly about the patient's goal (your goal), sometimes with an emphasis on "*your*" or in some examples by naming the person, for example ".h ¨Üches Ziel? (.) Herr X" (**".h Your goal? (.) Mr. X"** - B09 PTe Rx1_20.06)
- Different lexical terms are used in these questions, such as 'goals', 'expectations' and 'achievement', sometimes used in combination (see B20 above) or as clarification when the first question was not answered immediately, for instance: "*tss (.) kk (.) Und was für nes Ziel ? (0.8) was möchteder erreiche mit de Therapie*" (**tss (.) kk (.) And what kind of goal ? (0.8) what would you like to achieve with therapy"** – B06 PTf Rx1_17.43).

Apart from those common features, I argue that there are two assumptions embedded in the question: (1) that the patient has in mind, and a priori, one goal acceptable for physiotherapy; and (2) that he/she is able to articulate it. Let's now look at those assumptions and how they play out in the interaction.

Assumption 1: Patients have a goal

In Extracts 4.3 and 4.4 physiotherapists use a *wh*-question format to initiate the enquiry about goals.

The patient in Extract 4.3 consults the physiotherapist for a whiplash injury that occurred two months earlier. It is important to know that the patient has undergone physiotherapy treatment with another therapist, but was referred to the outpatient department so that her treatment would not be interrupted while her treating physiotherapist was on holiday. The patient is currently on medical leave (she works in a factory) but continues to do housework, although with difficulty. The sequence takes place in the beginning of the second consultation. The prior discussion was about the activities that are difficult for the patient to do. Some bodily features that I argue are particularly salient to the activity of goal setting are included in the transcript. The moment of the picture taken is indicated in the transcript with an asterisk (in the second line of the translation) and the red arrow (on the left side) marks the start of the *wh*-question.

Extract 4.3: B10 PTg Rx2 4.22

Image 1

3	*[11](0.9) *((Physiotherapist turns away from patient, puts the chart on the bed and starts writing))*
4 Patient	Okay
	Okay
5	(1.0)
6 Physio	Eh:::::m hh.
	Uh::::m hh.
7	(1.0)
8 Physio	Die nächste Frage ist ↑die (.) was erwarten sie von der Therapie im Moment.
	The next question is ↑this (.) what expect you from the therapy at the moment.
	The next question is this one (.) what do you expect from therapy at this time
9	was ist ihr Ziel. was möchten Sie erreichen.
	was ist your goal. what would like you to achieve.
	what is your goal. what would you like to achieve.
10	(0.9)
11 Patient	Dassi mini Bewegige wieder cha mache
	That I my movements again can make
	That I can move again
12	(2.0) *((physiotherapist is writing in his chart))*
13 Physio	Ihre Bewegungen das heisst?
	Your movements that means?
	Which means that you can move again?
14	(0.2)
15 Patient	Auso dass mer ned immer wieder schwindlig wird
	So that me not always again dizzy get
	So that I don't get dizzy all the time

[11] The image is marked with an asterisk * in the in the second line of the text where it occurs

16 (0.7)

17 Physio **↑Mhm**

18 (1.4)

19 Patient >Dass i nüme so igschränkt bi<

>That I not any more so restricted am<

That I am not so restricted anymore

20 (2.9)

21 Physio Also weniger Schwindel.

So less dizziness.

So less dizzy.

22 Patient Ja

***Yes**

Image 2

23 (0.7)

24 Physio Wenn Sie weniger Schwindel (.) ↑hä□en (.) was würden Sie dann machen.

If you less dizziness (.) ↑had (.) what would you then do.

If you were less dizzy what would you do then.

25 (1.3) *((Physio continues to look at the patient until patient starts to speak))*

26 Patient De würdi (.) d'Sache wieder schneller mache

Then would I (.) the things again faster make

Then I would do things faster again

27 (1.0)

28 Patient D'Arbeit schneller mache

The work faster make

Do the work faster

29 (0.8)

30 Physio Zum Beispiel Betten (.) schneller m[achen oder was]

For example beds *(.) faster m[ake or what]

For example to make the beds faster or what

31 Patient [Ja oder] jo

[Yes or] yeah

Image 3

32 (0.4)

33 Patient D'Chuchiarbeite-

The kitchen work-

The kitchen work

34 (1.0)

35 Physio Im Moment sind Sie langsam

At the moment are you slow

At the moment you are slow

36 Patient Jo de machi immer [alles] längsämer

Yeah then do I always [everything] slower

Yeah I do everything slower all the time

37 Physio **[Mhm]**

38 (2.4)

39 Physio Also Ihren Haushalt (.) quasi schneller [(.)] über die Runden bringen ↑mhm

So your household (.) like faster *[(.)] over the rounds bring ↑mhm

So to do your housework faster mhm

40 Patient [Ja]

[Yes]

Image 4

When posing the initial question, the physiotherapist uses three words (expectation, goal, and achievement) for the goal enquiry: "*What do you expect from therapy at the moment - What is your goal - What would you like to achieve.*" (lines 8 - 9). It is interesting to note that the therapist does not use a rising pitch for the questions, but only for the beginning of the question sequence indicating the start of a new topic (Schegloff, 2007a). As shown previously in Section 4.2.1, the physiotherapist treats the goal sequence as an independent activity. In addition to the three vocal aspects (new topic, *wh*-question, pitch), the physiotherapist uses gaze to coordinate his talk with bodily actions. Even though the physiotherapist looks at his chart for long stretches, at certain moments his shift of gaze to the patient is associated with the patient's response (line 21 – image 2). The gaze shift is also coordinated with small pauses (line 30 – image 3, line 39 – image 4).

The patient then provides an answer ("*That I can move again"* - line 11), which is used as the starting point for determining a physiotherapy goal. The physiotherapist begins this process by repeating the patient's terms *"Which means that you can move again?"* (line 13). The patient provides some more details (line 15 - "*So that I don't get dizzy all the time*") and, after a short pause, adds "*that I am not so restricted anymore*" (line 19). In a list of items, the last one usually is addressed first (Jefferson, 1990), but this is not the case here. The physiotherapist does not take up the latter point, but comes back to the patient's reported dizziness by repeating the same words prefaced by a "*so*" (line 21 – *"So less dizzy"*). Bolden (2006) describes "*so*" as an interactional resource used to demonstrate engagement with and interest in the affair of the interlocutor. This discourse marker can also be used to launch a new action, which is what the physiotherapist does with the next question: "*if you were less dizzy (.) what would you do then*" (line 24). This question links to one of the initial questions (line 9 – "*what would you like to achieve*"). I suggest that through questioning (and repeating) the physiotherapist and the patient collaboratively construct a goal.

The further talk (lines 26 – 35) has the task of defining more specific activities relevant for physiotherapy. Initially, the patient's response to this question is relatively broad (line 26 – "*Then I would do things faster again*"), but then she adds some more details (line 28 – "*to do the work faster").* The physiotherapist proposes housework activity based on previous exchanges (line 30 – "*For example to make the beds faster"*). Once the activity is agreed upon (line 31) and expanded by the patient (line 33 – "*The kitchen work*"), the physiotherapist enquires about the speed of the work (line 35 – *"At the moment you are slow"*). This statement is based on the patient's previous description of being slow (line 26 and 28). The patient aligns with the physiotherapist by using a type-conforming response (Raymond, 2003). The physiotherapist uses a "*so*"-prefaced formulation ("*so to do your housework (.) faster ↑mhm*" - line 39) in order to close down this turn. The patient ratifies this suggestion with a "*Yes*" (line 40), and the therapist moves on to the next topic.

Formulations will be discussed in more detail in Chapter 6, but I have showed here how the physiotherapist initiates the enquiry about goals and collaboratively reformulates the patient's responses. The assumption of the *wh*-question is that patients have a 'pre-set' physiotherapy goal, but the physiotherapist and the patient collaboratively construct it in a way that is acceptable for physiotherapy. In this smooth interaction, the physiotherapist and the patient both seem to orient to the same assumption – that the patient has a single goal, in mind.

Through my analysis of the previous example, I show how a patient responds to the goal enquiry and how a therapist then does work on those responses until a goal can be ratified by both patient and therapist. The practice of physiotherapists in reformulating broad responses from patients into more specific goals acceptable for physiotherapy entails different interactional resources and will be explored in detail in Chapter 6. However, with Extract 4.3 I show, how through this work participants maintain the assumptions that patients have a goal.

The next example – Extract 4.4 – demonstrates that the alternative question format (abbreviated *wh*-question) conveys the same assumptions about goals. Even though an abbreviated question does not include a *wh*-word, I argue that it is conversationally and interactionally treated as a *wh*-question (Schegloff and Lerner, 2009). For ethical reasons I am not able to show any picture frames, but describe some relevant bodily aspects of talk in the transcript (see Section 3.5.3).

The patient is referred to physiotherapy after shoulder surgery. He was discharged from the hospital a few days before, however, without the physician's referral letter. The extract starts with a discussion of the surgeon's information about what the patient was allowed to do. This exchange takes place at the end of the information-gathering phase before the physiotherapist starts the physical examination procedure.

Extract 4.4: B09 PTe Rx1_20.06

1 Physio	.hhh Het eh:m de Doktor D gseit was er nöd dörfed mache. (.)
	.hhh Have uh:m the Doctor D said what you not are allowed to do. (.)
	.hhh Did uh:m Doctor D say what you are not allowed to do.
2	m o m e n t [an.]
	at the mome[nt.]
3 Patient	[Er] het mer gseit eifacht ned morkse oder
	[He] had me told MOD not push huh
	He told me *eifacht*[12] not to push it huh
4	(0.4)
5 Physio	Ned mork[se (.)] ned lüpfe [eso das eifach.]
	Not to pu[sh (.)] not to lift [PART this MOD.]
	Not to push it (.) not to lift *eso*[13] like that *eifach*
6 Patient	[Ja] [ja (.) ja]
	[Yes] [yes (.) yes]
7 Physio	**↑Mhm**
8	(8.2) *((Physiotherapist writes in chart))*
9 Physio	Gue:t
	Goo:d

[12] Approximate translation: "*just*"
[13] Approxiamte translation: "*eso das*" could be "*that's that*"

10 (0.7) *((Physiotherapist turns page, still looking down))*

11 Physio .h Üches Ziel? (.) Herr X

.h Your goal? (.) Mister X

12 (0.4) *((Physiotherapist shuffles paper and looks up))*

13 Physio do ide [Therapie]

here in the [therapy]

14 Patient [Jo eifacht] (.) ganz schmerzfrei werde oder (.) [ganz klar] oder

[PART MOD] (.) totally pain free to become huh (.) [totally clear] huh

***Jo eifacht*[14] to become completely pain free huh (.) that's clear isn't it**

15 Physio [Schmerzfrei] werde

[Painfree] to become

To become pain free

As in previous examples, a new topic is introduced after closing down the prior sequence. After the discussion about the surgeon's prescription, the therapist closes the sequence down, both verbally ("*good*") as well as in an embodied way by turning the page of the patient's chart (line 10). The new topic starts in line 11 with an abbreviated goal enquiry ("*your goal?*"). In addition to this first part, the physiotherapist adds "*Mister X"* (line 11). This name reference is in contrast with the exchange about the physician's expectations (line 1 – 6). The patient's response *"to become completely pain free"* (line 14) is ratified by the therapist's acknowledging vocally that she has heard and understood the patient's response (repeat as a linguistic device – see Hutchby, 2005 and Chapter 6) and by documenting that response in the chart (line 15).

The reviewed case shows that abbreviated questions in this context have the same function as *wh*-questions. In both goal enquiry episodes presented in this section, the assumption that patients have a goal in mind is oriented to by both participants. While Extract 4.3 and 4.4 show examples prompted by physiotherapists' enquiries and subsequent questions about specific goals, the next example shows how the patient volunteers information without being prompted by the therapist, thereby including a second assumption in the goal enquiry: that patients are able to articulate goals.

[14] Approximate translation: "*well just"*

Assumption 2: Patients are able to articulate goals

While the previous examples demonstrate that physiotherapists embed the assumption – that patients have a goal acceptable for physiotherapy – in their question, there is a second assumption embedded in the *wh*-question: that the patient is able to articulate that goal. The following episodes show – in addition to the first assumption – this second assumption. I argue that in order to be able to formulate goals, either the patient must have knowledge about the nature of physiotherapy and have specific expectations with regard to physiotherapy or the patient must have had previous experience with physiotherapy treatment.

The first example, Extract 4.5, shows a smooth interaction using a *wh*-question. The question is asked in the beginning of the first consultation, and the patient provides information about goals without being prompted. The beginning of the extract illustrates the end of the sequence regarding the patient's profession (a nurse) and her employment status. The discussion in the first few lines is about the part-time employment (80%) the patient is temporarily holding, not due to health problems but by choice. The patient seeks physiotherapy for a knee problem: she gets knee pain after one hour of running and has difficulty kneeling down. The participants in this particular recording did not consent to the use of picture frames. I have shown gaze and writing in the transcript (refer to 3.5.3 – ethical considerations).

Extract 4.5: B04 PTd Rx1_6.58

8 Physio	.hh Wieviel Prozent de.
	.hh How many percent then.
	.hh What is the percentage of employment then.
9 Patient	Achzig
	Eighty
	Eighty percent
10	(7.3) *((Physiotherapist writes in chart))*
11 Physio	**tss**
12	(0.4) ***((****Physiotherapist stops writing but continues to look at her chart))*
13 Physio	E:::::hm (.) J:a und was isch dis Ziel?
⇨	**U::::hm (.) Ye:s and what is your goal?**
14	(0.5) ***((****Physiotherapist looks at patient))*

15 Patient Mis Ziel isch dass ich wieder cha go jogge so wienich körperlich au ↑mag

My goal is that I again can go to jog like the way I physically also ↑be able

My goal is that I can go running again as much as I am physically able to

16 Physio **↑Mh[m]** ***((****Physiotherapist writes in chart))*

17 Patient [o]hni dass mi de Schmerz behinderet

[wi]thout that me the pain handicapped

without being bothered by the pain

18 (2.1) *((Physiotherapist continues to write in her chart))*

19 Patient Eifacht dass ich die Sportarte wonich gern mache eifach wieder cha usfüehre=

MOD that I the types of sports that I like to do MOD again can execute=

Eifacht[15] **that I can *eifach***[16] **do the sports again that I like to do and that I can**

20 =und mi frei (.) cha füehle und-

=and myself free (.) can feel and-

feel myself ready and-

21 (0.5)

22 Patient [Jo]

[Yes]

23 Physio **[Mhm.]** *((Physiotherapist looks at patient))*

24 (1.1)

25 Physio Machsch no anderi Sportarte i dem Fall oder?

Do you do still other types of sport in that case huh?

In that case do you do other sports as well huh?

Similarly to cases examined above, an explicit topic and activity change is evident in that the therapist writes down (assumingly) their previous discussion (line 10), stops writing but still looks at the chart (line 12), utters a "*yes*" (line 13 - a sequence-closing third; Schegloff, 2007a), and initiates the goal activity using –*and* as preface (line 13). Heritage and Sorjonen (1994) demonstrate that in medical interactions -*and*-prefaced questions indicate a routine or agenda-based character of the enquiry. This fact is confirmed in Extract 4.5 in which there is no further exploration of the patient's response. The physiotherapist uses a response token with rising intonation ("*↑Mhm*" - line 16, see Gardner, 1997, 2001 and Chapter 6), and the patient continues her talk without delay. In line 19, the patient adds additional information with regards to the

[15] Approximate translation: "*simply*"
[16] Approximate translation: "*just*"

goal, before the physiotherapist closes down the sequence with a falling "*Mhm.*" (Gardner, 2001).

Another salient point in this extract is the nature of the questions. Although the –*and*-prefaced goal question is constructed as routine enquiry, the patient's response indicates that there is a difference between questions about employment status and the goal enquiry. While the question "*What is the percentage of employment*" (line 8) is answered by the patient with one word ("*Eighty*" – line 9), the question "*what is your goal?*" (line 13) is responded to the patient with a full repeat "*My goal is that I can go running again as I am physically able to without being bothered by the pain*" (line 15 and 17). Full repeats might show that the questioning action is somehow problematic (Robinson and Kevoe-Feldman, 2010). However, I will not go further into details about the patient's response here as this will be the topic of Chapter 5.

While the patient in the extract above is immediately able to formulate an 'acceptable' goal, the next example helps to make my point clear that exchanges about goals taking place within the first minutes of the consultations require a certain 'expertise' in physiotherapy. Extract 4.6 shows a patient who has previously been treated by the same physiotherapist for the same problem (hip arthritis). The goal enquiry takes into consideration the patient's previous experience. The patient is considered too young for hip replacement surgery, and the physician prescribed nine physiotherapy sessions to reduce the pain and improve muscle strength.

Extract 4.6: B19 PTb Rx1_5.56

1 Physio	Was wär s'Ziel de jetzt vudere (.) Therapie[phase no einisch]	
	What would be the goal then now of this (.) therapy [phase once again]	
⇨	**What would be the goal for now for this therapy phase this time**	
2 Patient		[He jo ↑stabili]siere (.)
		[He PART to ↑stabili]se (.)
		He *jo*[17] to stabilise

[17] Approximate translation: "*well*"

3	m[eh gi]t- meh liet jo nümm din[ne]	
	m[ore is-] more lies PART not any more in [it]	
	more there is- there is *jo*[18] not much more possible	
4 Physio	[Ja]	[↑Mh]m
	[Yes]	**[↑Mh]m**
5	(2.9)	
6 Patient	Aso i denke meh liet nümme dinne	
	PART I think more lies not any more in it	
	***Also*[19] I think there is not much more possible**	
7	(0.4)	
8 Physio	Ja	
	Yes	

The words "*for now*", "*for this therapy*" and "*this time*" (line 1) indicate that the physiotherapist enquires about a current reason for consultation. The therapist formulates the question in a hypothetical form ("*What would be the goal*"), which is unusual in my data. Responding to the therapist's question, the patient utters a goal ("*to stabilise*"- line 2) that he would be happy to achieve as an outcome for therapy, treating the question as, for the most part, unproblematic.

This extract demonstrates that therapists not only embed the assumption that patients have a goal into their questions, but also that patients are able to articulate this goal. However, this capacity to articulate a physiotherapy goal requires some specific knowledge about or experience with physiotherapy. It will become evident in the next examples that this capacity cannot be expected from all patients. A straightforward question about goals might not pose a problem for some patients, but there is evidence in my data that this formulation is not suited to all patients. The next section provides some examples of cases in which the goal enquiry can be interactionally challenging.

[18] Approximate translation: "*still*"
[19] Approximate translation: "*actually*"

4.2.3. When assumptions are not shared or mutually oriented to

In previous examples, I showed how patients and physiotherapists achieve interactionally unproblematic discussions about goals and how physiotherapists convey assumptions about goals. Yet, I have found six cases in my data in which those assumptions are evidently not shared and interactional difficulties associated with this are noticeable.

In the following Extract 4.7, the assumption that the patient has 'an idea' comprising a physiotherapy goal is challenged by the patient. The patient consults the physiotherapist for his low back pain due to a work injury. He works as a mechanic and has been on medical leave for the previous two weeks. The physiotherapist has just finished the information-gathering phase and comes to the end of this activity.

Extract 4.7: B16 PTe Rx1 16.35

1 Physio	Süsch n:o öppis woder vorether gmacht heit vorem ↑Sturz	
	Else still anything that you before made had before the ↑fall	
	Anything else that you did before the fall	
2	[woder jetzt nüme ↑chöit]	
	[that you now not any more ↑could]	
	that you are not able to do anymore?	
3 Patient	[Ehm jo] fitness hani gmacht aber das hani ufgeh	
	[Uhm PART] fitness have I done but that have I up give	
	Uhm *jo*[20] I did some fitness training but I have given it up	
4 Physio	**↑Mhm**	
5 Patient	°Für die Ziet°	
	°For the time°	
	For the time being	
6 Physio	Ja.	
	Yes.	
7	(4.1)	
8 Physio	Okay (.) .hh Was isch üches Ziel do vu de Therapie	
	Okay (.) .hh What is your goal here of the therapy	
⇒	**Okay (.) .hh What is your goal here for therapy**	
9	(1.7)	

[20] Approximate translation: "*well*"

10 Patient °Kei Ahnig he[hehe°]

°No idea he[hehe°]

11 Physio [hehehe] Werum siet ihr do was söll andersch werde [dhh]

[hehehe] Why are you here what should different become [dhh]

hehehe Why are you here what should be different

12 Patient [°Wi]eder (laufe) denki°

[°Ag]ain (walking) think I°

To walk again I think

13 (0.2)

14 Physio **↑Mhm**

15 (3.5) *((Physiotherapist writes in chart))*

16 Physio Heiter e Vorstellig vu de Schmerze her.

Have you an imagination/aspiration of the pain from.

Do you have an idea with regard to your pain.

17 (1.0) *((Physiotherapist shifts gaze to patient))*

18 Patient °Aso wie meined Der Vorstellig°

°PART what mean you imagination°

***Also*[21] what do you mean by an idea**

19 Physio Aso säged[er- ehm (.) jo i] wott schmerzfrei si und-

So say y[ou- ehm (.) yes I] want painfree to be and-

So you say- ehm yes I would like to be painfree and-

20 Patient [Dass sie wäg göi]

[That they away go]

That it goes away

21 (1.5)

22 Physio So chönne schaffe oder heiternech- was heit der do für Vorstellige

So be able to work or have you- what have you here for imagination

To be able to work or do you have- what do you expect

23 (1.0)

24 Patient °Jo ich ha scho mol Physiotherapie gha [(.)] heile tuet me ned gross (.) aber es isch meh°(.)

°PART I have already once physiotherapy had [(.)] cure does it not big (.) but it is more° (.)

***Jo*[22] I have had physiotherapy once before (.) it is not possible to cure it but it is more**

25 Physio **[↑Mhm]**

26 Patient e chlini Hülf für (.) fürs Le:be oder für (.) dass es echli [bess]er geit [eigentlich] aber eh-

a little help for (.) for the li:fe or for (.) that it a bit [bett]er goes [actually] but uh-

a little help for- for living or for the fact that it will actually be a bit better but uh-

[21] Approximate translation: "*actually*"

[22] Approximate translation: "*well*"

27 Physio		[Ja]	[Mhm]
		[Yes]	**[Mhm]**
28 Patient	jo i hoffe mer scho dass sie wäg göih		
	PART I hope me still that they away go		
	***jo*[23] I still hope that it will go away**		
29 Physio	**Mhm**		

((Physiotherapist writes in chart and continues asking about previous physiotherapy treatment))

This extract shows features covered in previous sections (topic transition, *wh*-question to initiate goal enquiry). However, in this example the patient does not respond immediately to the therapist's question (line 9). There is a delay of 1.7 seconds followed by a soft "*No idea*" accompanied by laughter. By responding in such a way, the patient denies having the knowledge required to provide an answer. This non-access response (Raymond, 2003) creates interactional difficulties, and so this Extract 4.7 exemplifies the potential non-straightforwardness of the response to a question about goals (see Schegloff and Lerner, 2009). The speaker's question puts pressure on the receiver to respond in a particular way, and participants have to overcome that interactionally delicate situation. In this example, shared laughter (line 10 – 11) is used as a resource to move the interaction forward. Laughter is identified as an indication of having a shared understanding of solving interactional difficulties (Hakaana, 2002). The physiotherapist then rephrases the question, adding clarification by asking "*Why are you here what should be different*" (line 11). The patient's response is mitigated ("*I think*" - line 12) and spoken softly which attenuates his statement (Schegloff, 2007a).

The response token from the physiotherapist (line 14) gives the floor immediately back to the patient (see Chapter 6 and Gardner, 2001), but the patient does not contribute more information. After a prolonged pause (line 15) in which the physiotherapist writes in her chart, she enquires further about the patient's ideas (line 16). The gaze shift from the physiotherapist is coordinated with the patient retaking the floor. Instead of answering, the patient counters the question with another question

[23] Approximate translation: "*well*"

(line 18 – "*Well what do you mean by idea*"). The function of a counter is to defer the answer (Schegloff, 2007a). Doing that, the patient reverses the direction of the question's constraint. As soon as the therapist answers (line 19), the patient provides a response in overlap with the physiotherapist ("*That it goes away*" – line 20), making reference to his low back pain. As the patient does not provide more information, the physiotherapist proposes a functional goal rather than a symptomatic one ("*to be able to work or do you have- what do you expect*" – line 22). The multiple accounts are uttered by the patient in a soft voice, initiated with a "*jo*" which could be translated with "*well*" (line 24 - 28). The patient does not affiliate with the physiotherapist's suggestion (Stivers, 2008), and the sequence ends with a broad goal response indicating his wish to be that his pain decreases ("Jo *I still hope that it will go away"* – line 28). This response apparently is accepted by the therapist as she moves on to the next topic.

This interaction illustrates that when the physiotherapist starts out the goal enquiry with the assumptions that patients should articulate a goal without any "outside" help - independently, the interaction can become troublesome for the patient if he or she is not able to respond in that way. By asking such questions at the outset, physiotherapists potentially create discomfort for patients who are not able to respond independently to a goal enquiry. I argue that this case reveals evidence of specific interactional difficulties that may occur: laughter, delays and lengthy interactions with multiple accounts from the patient.

The next example offers some insights into an interaction of a goal enquiry that is treated by the patient as problematic. The sequence takes place in the beginning of the first consultation. While the physiotherapist in the previous extract was required to rephrase her goal enquiry from "*what is your goal?"* to *"why are you here?"*, this is not the case in the next example. The physiotherapist maintains the constraint of the question by minimally acknowledging the patient's insert expansion (Schegloff, 2007a).

In Extract 4.8, the patient seeks physiotherapy services for her acute low back pain problem. This episode takes place in the beginning of the first consultation and the physiotherapist enquires about the patient's leisure activities before entering the discussion about the next appointment with the physician, just before entering the goal enquiry.

Extract 4.8: B11 PTd Rx1_4.43

60 Physio	Heiter no en Kontrolltermin in nächschter Zi[et ein]isch bim Ar[zt?]	
	Have you still a control appointment in next ti[me on]ce with the doct[or?]	
	Do you already have another medical appointment scheduled for the near future?	
61 Patient	[Ja]	[Nöch]scht Mänt[ig]
	[Yes]	**[Nex]t Monda[y]**
62 Physio		[Nö]chscht Mäntig
		[Ne]xt Monday
63	(0.9)	
64 Physio	Isch der-	
	Is the-	
	It is the-	
65	(0.4)	
66 Patient	Achtezwänzgisch[t]	
	Twenty - eigh[th] *((of the month))*	
67 Physio	[Ach]tezwänzgischt	
	[Twen]ty-eighth	
68	(4.3) ((*Physiotherapist writes in chart, then turns back to patient))*	
69 Physio	Was isch eues Ziel?	
→	**What is your goal?**	
70	(1.3)	
71 Patient	Mis Ziel?	
	My goal?	
72 Physio	**↑Mhm** *((Physiotherapist nods))*	
73 Patient	Dass ich cha si ohni Schmärze	
	That I can be without pain	
	((Physiotherapist turns to chart to write))	

In line 60, the therapist asks the patient about the next doctor's appointment and documents the response in the chart (line 68). The enquiry about goals is introduced

without a vocal indication of closing the prior topic. The patient's response is not immediately forthcoming. The patient then returns a question with an 'insert expansion' (line 71 – "*my goal?*"). Insert expansions are interactional devices that compromise the progressivity of the sequence (Schegloff, 2007a; p. 100). In this extract – as in Extract 4.5 – the question can be somewhat difficult to answer. While the patient responds with no delay to questions about leisure activities (data not shown – see Appendix G) or doctor's appointments (line 61), she defers the question about goals (line 73). I argue that the therapist in this extract maintains both assumptions that the patient has a goal (first assumption) and is able to articulate it (second assumption), but that even though the patient produces a response, she does so in a less than straightforward way.

In summary, goal enquiry initiated by a *wh*-question or an abbreviated *wh*-question is generally treated as a new topic. Prior topics are closed down before new ones start. *Wh*-questions are frequently combined with a rising pitch and increasing volume at the end of the utterance and are coordinated with gaze in order to mobilise a response. The *wh*- questions convey the assumptions that patients do arrive at a goal that is acceptable for physiotherapy (assumption 1) and that they are able to articulate it (assumption 2). However, when patients do not provide straightforward answers, physiotherapists sometimes are able to use the patients' responses and collaboratively construct them into for physiotherapy acceptable goals. Interactional resources deployed to achieve this action are repeats and "*so*"-prefaced formulations (Chapter 5). This transformation process, as I call it, will be analysed further in Chapter 6. Yet, difficulties arise when participants do not share the assumptions built into the *wh*-question. The interactional devices used by patients to orient to physiotherapists' assumptions are either a counter (extract 4.7) or an insert expansion (extract 4.8).

In general, when questions are asked, it is expected that responses are forthcoming. When a recipient of a question does not provide an answer, s/he may account for not answering by saying that she does not know (Sidnell, 2013), which is similar to the Extract 4.7. On the other hand, questioners may orient to the absence of

an answer by pursuing an answer with a follow-up question (Extract 4.3) or drawing inferences as to why an answer is not being provided (Sidnell, 2013, p. 80).

With the next Extract 4.9 I demonstrate that when a patient does not respond in a way that allows the therapist to ratify the answer, the interaction becomes much longer as the physiotherapist accounts for the reason for the enquiry and the usefulness of the response. This is a nice example of participants making an interactional norm explicit in subsequent talk, as there is a certain violation of this social norm (Sidnell, 2013, p. 81).

Accounting for action of enquiry

In the last section, I illustrated *wh*-questions and their underlying assumptions, as well as the consequences of those assumptions. The following episode documents the consequences of a goal enquiry extending into a lengthy interaction in which the therapist accounts for her enquiry. This case gives us insight into the therapist's conceptualisation of goal-setting and expectations with regard to an appropriate response to the goal enquiry. This extract demonstrates that goals are treated as acceptable when they are measurable and timely.

Extracts 4.9 to 4.12 is one episode of goal enquiry divided into four parts and shows how the physiotherapist initiates the goal enquiry (Extract 4.9 – 1st part), how she pursues an answer with regard to the initially stated goals (Extract 4.10 – 2nd part), how she accounts for her attempt to get an 'acceptable-for the context' response from the patient (Extract 4.11 – 3rd part) and how the patient and therapist then mutually construct the goals (Extract 4.12 – 4th part). The patient is referred to physiotherapy because of her chronic back pain. Initially, the patient formulates her goals, but those goals are not specific enough so the physiotherapist pursues the patient's response in order to specify that initial response. The extract starts with a discussion about the Nordic walking training the patient used to do but stopped one-and-a-half years ago (data not shown here – see Appendix G).

1st part: Initiation of the goal enquiry (lines 17 – 35)

Extract 4.9: B20 PTc Rx1_23.22 – Part 1

17 Physio ts .hhhhhh (.) Und (.) Eues:: Zi:::el ↑jetzt oder Eui Erwartig ad ↑Physiotherapie?

ts .hhhhhh (.) And (.) your:: go::al ↑now or your expectation for ↑physiotherapy?

18 (1.7) *((Physiotherapist looks at the chart until the end of the pause, then looks up))*

19 Patient Jo dass mer eifacht löst ↑irgend[wie] (.) >wenns de eifach- <

PART that me MOD loosen ↑some[how] (.) >if it does then MOD-<

***Jo*[24] that it *eifach*[25] loosens up again somehow (.) if it *eifach*[26]-**

20 Physio **[↑Mhm]** *((Physiotherapist starts writing in chart))*

21 (1.7) *((Physiotherapist writes in chart))*

22 Patient dass es eifacher ↑wird

That it easier ↑will be

that it will become easier

23 (3.8) *((Physiotherapist writes in chart))*

24 Physio **↑Mhm**

25 (6.3) *((Physiotherapist writes in chart))*

26 Physio Bi wellne Aktivitäte stört Euch denn das Problem im Moment am meischte=

With which activities bothers you then the problem at the moment the most=

In what activities does the problem bother you the most this time

27 woder säged (0.6) das möchti wieder besser chönne mache?

that you say (0.6) that would like I again better could do?

about which you say (0.6) I would like to be able to do that better again?

28 Patient Eigentlich alls

Actually everything

29 Physio ↑Mhm Was wäred die drü Wichtigschte?

↑Mhm What would be the three most important?

Mhm What would be the three most important activities?

30 (1.0) *((Physiotherapist looks at patient))*

31 Patient Jo mol (.) dass i wieder richtig cha schtoh [und-]

PART once (.) that I again correctly could stand [and-]

***Jo*[27] at first that I could stand correctly again and-**

32 Physio **[↑Mh]m** *((Physiotherapist starts writing in chart))*

33 (1.8) *((Physiotherapist writes in chart))*

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[24] Approximate translation: "*well*"
[25] Approximate translation: "*just*"
[26] Approximate translation: "*simply*"
[27] Approximate translation: "*well*"

34	Patient	Eifacht allgemein ↑d'Bewegig
		MOD in general ↑the movement
		***Eifacht*[28] generally the movement**
35		(0.2)

After the closing down of the previous sequence the physiotherapist uses an abbreviated format with a rising intonation to initiate the goal enquiry (line 17 – "A*nd (.) your:: go::al ↑now or your expectations for ↑physiotherapy?"*). The question starts after a long in-breath and is *and*-prefaced. The function of the *and*-prefaces is to keep the topic on track (Heritage and Sorjonen, 1994). After a delay (line 18), the patient responds with a goal by using an impersonal pronoun (line 19 – "*that it* eifach *loosens up again*"). Because the patient's response is not ratified vocally by the therapist (line 21), the patient provides additional information (line 22 – *"that it will become easier*"). In contrast to some of the earlier examples in which I showed that patients respond with "*that I can go running again*" (see also Chapter 5), this patient uses until line 31 only impersonal description of goals. After those two goal statements (line 19 and 22), the physiotherapist documents the responses in her chart, but does not seem to accept the responses completely as she continues to enquire about activities that bother the patient the most (line 26 - 27). The physiotherapist changes the formulation of the question from "goals" to "activities to achieve" in order to elicit the patient's response. The patient's answer continues to be extensive (line 28 – "*Actually everything"*), and the physiotherapist pursues the enquiry about activities (line 29). In line 31, the patient provides a first activity (standing), but finishes again with a generalised description (line 34 – "Eifacht *generally the movement*"). As this answer is apparently not sufficient for the purpose of setting goals, the physiotherapist then starts the second part of the enquiry in which she tries to specify those activities.

[28] Approximate translation: "*just*"

2nd part: Pursuit of questions (lines 36 – 55)

Extract 4.10: B20 PTc Rx1_23.22 – Part 2

36 Physio ↑Mhm aso was zum Biespi[el?]
↑Mhm so what for exam[ple?] *((Physiotherapist looks at patient at the end of the turn))*

37 Patient [Eb]e dass do de Rügge wieder-
[PART] that here the back again-
Ebe[29] **that the back here**

38 (0.7)

39 Patient ich weiss oned beweglicher oder-
I know also not more flexible or-
I don't know either more flexible or-

40 Physio Genau [wo stört nech] wenn der was mached stört nech i Euem Alltag störts=
Exactly [where bothers it you] when you what do bothers it you in your everyday bothers it=
Exactly where does it bother you when you do what does it bother you during your day

41 Patient [Weicher oder-]
[Softer or-]

42 Physio =nech vor allem dass (.) d'Beweglichkeit nid so geit
=you especially that (.) the mobility not so goes
does it bother you especially that the mobility is not so good

43 Patient Jo guet bim Schaffe [bim] Autofahre bim- [phhh] (.) bim Putze eigentlich immer
PART good at work [while] car driving while [phhh] (.) while cleaning actually always
Jo[30] **alright at work while driving a car while phhh while cleaning actually always**

44 Physio **[Mhm] [Mhm]**

45 (1.2)

46 Physio ↑Mhm (.) Was sölli no näh sölli no s'Autofahre und s'Putze näh oder gits anderi-
↑Mhm (.) What should I s□ll take should I still the car driving and the cleaning take or is there other-
Mhm What should I take should I take the driving and the cleaning or is there anything

47 öppis anders wo no wichtiger wär
something else that still more important would be
else that would be more important

48 (1.0)

49 Physio vu Aktivitäte wo igschränkt si
of activities that restricted are
in terms of activities that are restricted

50 (0.3)

[29] Approximate translation: "*just*" (similar to "eifach")
[30] Approximate translation: "*jo guet*" could be best translated as "*fair enough*" or "*alright then*"

51 Patient	Jo guet s'Laufe das ↑geit	
	PART good the walking that ↑goes	
	***Jo*[31] alright walking goes all right**	
52	(0.2)	
53 Physio	**↑Mhm**	
54	(4.0)	
55 Patient	Jo eifacht der ↑Alltag ↑allgemein	
	PART MOD the ↑every day ↑general	
	***Jo*[32] *eifacht*[33] the day-to-day activities in general**	

The therapist's pursuit shapes the goals in such a way that those new goals appear acceptable for physiotherapy. She uses formulations like "*So what for example*?"(line 36) to specify the activities, "*exactly where does it bother you when you do what*" (line 40) to get an unambiguous response. In the beginning of this second part the patient indicates with *ebe*-prefacing (line 37) and no-knowledge response ("*I don't know either*" - line 39) that she does not claim to have access to the knowledge about goals (see also Chapter 5). In line 42 the therapist proposes a goal "*does it bother you especially that (.) the mobility is not so good*". The patient's reply is all-inclusive (line 43 – at work, while driving, while cleaning, actually always) which seems not acceptable to the therapist. She proposes "*driving*" and "*cleaning*" as potential activities (line 46), which are not confirmed by the patient. Instead, the patient suggests activities she is capable of doing (*"*jo guet *walking goes all right*" - line 51) and finishes with another not particularly specific goal ("jo eifacht *the day-to-day activities in general*" – line 55). At this moment, the physiotherapist starts to account for her enquiry. She responds to this turn with an acknowledgment token ("*Mhm mhm*") and explains to the patient what she is trying to do and brings thereby implicit orientation to the surface for the patient to understand and the analyst to observe.

[31] Same as previous expression: "*alright then*"
[32] Approximate translation: "*well*"
[33] Approximate translation: "*just*"

3rd part: Account for goal enquiry (lines 55 – 67)

Extract 4.11: B20 PTc Rx1_23.22 – Part 3

55 Patient Jo eifacht der ↑Alltag ↑allgemein
PART MOD the ↑every day ↑general
***Jo eifacht* the day-to-day activities in general**

56 Physio Mhm mhm I probieres sochli wie feschtzlegge will es isch (.) .hh schwieriger
Mhm mhm I try a bit like to define because it is (.) .hh more difficult
Mhm mhm I am trying to define a bit because it is .hh more difficult

57 nächher z'verglieche wenns irgend alls [isch] als wemme mol- es git jo viel=
afterwards to compare if it any all [is] as if one PART- there are PART a lot of=
to compare afterwards if it is everything than if there are *mol-*[34] there are *jo*[35] a lot of

58 Patient **[Mhm]**

59 Physio =Sache das [heisst jo ned] dasses denn nume die drü si aber das isch denn=
=things that [mean PART not] that it then only the three are but this is then=
things that *jo*[36] does not mean that there are only those three but it is then like

60 Patient [Ja]
[Yes]

61 Physio =so wie womes denn so chli cha feschtma[che und] drum frogeni echli- (.) .hh
=like when one then so a bit can defi[ne and] that's why ask I you a bit (.) .hh
when one can define it a bit and that's the reason I ask you to define it a bit .hh

62 Patient [Ja]
[Yes]

63 Physio denn müesseds echli Indikatore si wo- won Euch wichtig si [oder es git jo]=
then must there a bit indicators be that- that you important are [or there are PART]=
then there have to be indicators that- that are important for you or there are *jo*[37]

64 Patient **[Mhm]**

65 Physio =sicher ↑viel aber die einte sind echli wichtiger und die andere [echli weni]ger wichtig
=certainly ↑many but the ones are a bit more important and the others [a bit le]ss important

66 Patient [Ja]
[Yes]

67 (1.3)

The physiotherapist justifies the importance of the goal enquiry and specifies the purpose of generating a number of activities that can be reassessed. Over ten lines (56 –

[34] Approximate translation: "*once*"
[35] Approximate translation: "*still*"
[36] Same as 34
[37] Approximate translation: "*evidently*"

65), she constructs her talk by acknowledging the difficulty of the task for the patient. The physiotherapist starts with a statement about what she tries to accomplish (line 56 – "*I am trying to define a bit*"), but downgrades the assertion by minimising ("*a bit*") and by "*trying*" which still keeps the possibility open that a definition may not be achieved. In addition to the downgrading, the physiotherapist adds an account (line 56-57 - "*because it is .hh more difficult to compare afterwards if it is everything than if there are-*"). The physiotherapist chooses an impersonal form ("*it*") that she uses until line 61. This general introduction leads then to a more precise task for the patient who is supposed to provide important indicators, weighing the more important activities against the less important ones ("*then there have to be indicators that- that are important for you or there are certainly many but the ones are a bit more important and the others a bit less important*" – line 63 - 65). During the therapist's talk, the patient aligns with the physiotherapist using "*Yes*" (lines 60, 62, 66) and "*Mhm*" (lines 58 and 64) as well as nodding. Those discourse markers are described as devices of agreeing with the action in progress (Stivers, 2008), which is now shown in the Extract 4.12, where the patient provides a seemingly acceptable goal constructed collaboratively by both participants.

4th Part: Constructing acceptable goals (lines 68 – 80)

Extract 4.12: B20 PTc Rx1_23.22 – Part 4

68 Patient	Jo guet ebe i dem Moment ↑s'Putze
	PART good PART in this moment ↑the cleaning
	***Jo*[38] alright *ebe*[39] in this case the cleaning**
69 Physio	**↑Mhm**
70	(7.8) *((Physiotherapist writes in chart))*
71 Patient	Da isch ↑schwär
	This is ↑heavy
	That is difficult
72	(0.3)
73 Physio	S'Autofahre hender vori no [gnennt]
	The car driving have you before also [said]
	You mentioned also the driving before

[38] Approximate translation: "*alright then*"
[39] Approximate translation: "*just*"

74 Patient [S'Autofahre isch] no [ja]

[The car driving is] also [yes]

Driving a car also yes

75 Physio [↑Mhm] sölli mol das neh

[↑Mhm] should I PART this take

Mhm should I *mol*[40] take this one

76 Patient Jo jo

Yes yes

77 Physio Aso wüsster wemmer de im Verlauf merked dass isch eh- ned so wichtig es isch=

So know you if we then in the course realise that is uh- not so important it is=

So you know if we then realise during the course that it is uh- not so important

78 =öppis anders wos nech eigentlich [fascht no meh] stört de wechslemer de das=

=something other that it you actually [nearly still more] bothers then change we then this=

that there is something else that is actually bothering you more then we change it

79 Patient **[Mhm]**

80 Physio =isch ned in .hh Stein gemeisselt und de wetti gern wüsse wie guet dass es ↑geit

=is not in .hh stone carved and then would I like to know how good that it ↑goes

this is not something carved in stone and then I would like to know how well it goes

In line 68, the patient provides a goal that the therapist treats as acceptable for physiotherapy. This can be seen as the physiotherapist ratifies it vocally ("*Mhm*" – line 69) and in an embodied way (writing – line 70). The physiotherapist suggests a second activity ("*You mentioned also the driving before*" –line 73), which is then accepted by the patient ("*Yes yes*" - line 76) demonstrating her alignment with the action. Multiple sayings are described as a "resource speakers have to display that their turn is addressing an in progress course of action rather than just prior utterance" (Stivers, 2004, p. 260). After this utterance, the physiotherapist closes down the sequence by using a figurative expression (line 80 – "*carved in stone*"). Figurative expressions function as summary of a topic and in order to initiate the closing of the topic (Drew and Holt, 1998). The therapist attenuates the importance of the writing down of the goals as "*this is not something carved in stone*" (line 80) before she moves on to identify the level of problem with those activities (in the next part of the exchange not shown here – see Appendix G).

[40] Approximate translation: "*for now*"

The evidence shows here that when a patient does not provide an acceptable goal, i.e. to provide activity-related and measurable goals, the physiotherapist makes an effort by explicitly formulating what she is doing and accounting for the action.

This explication by the therapist defines not only what the patient is expected to know implicitly about the goal setting process, but this case is special as it gives us insight into the orientation when goals are not immediately accepted. It also shows what work has to be done interactionally to be able to align the patients' initial responses and the therapists' acceptance of the final goal to be documented in the chart. This episode together with the prior extracts brings us back to the main argument, that goal setting is not about eliciting patients' pre-determined goals, but it is actually about arriving at a consensus about a written goal that can be measured in future consultations.

Table 4.1 (p. 122) summarises all 15 episodes of goal setting topicalised by physiotherapists. It shows the different question format as well as the moment in which the enquiry takes place during the consultation.

Table 4.1: Question and its location

Code	Question and location
***Wh*-question in the beginning of the first consultation (first 7 minutes)**	
B04 PTd Rx1_6.58	Eeehm yes and what is your goal? Eeehm ja und was isch dis Ziel?
B19 PTb Rx1_5.55	What would be the goal then now for (.) this treatment phase again? Was wär s'Ziel denn jetzt vu (.) dere Therapiephase no einisch?
G02 PTn Rx1_00.18	And what is the goal. Und was ist das Ziel.
B11 PTd Rx1_4.53	What is your goal? Was isch eues Ziel?
***Wh*-question at the end of the information-gathering phase**	
B18 PTb Rx1_19.50	What would you like to achieve? (.) or what are the expectations for physiotherapy for you? Was würded gern erreiche? (.) oder was wär sochli d'Erwartig ad Physiotherapie für euch?
B07 PTe Rx1_14.33	Your goal? what would you here like to (.) achieve Üches Ziel? was möchted Ihr do (.) erreiche
B06 PTf Rx1_16.06	And what kind of goal? (0.8) What would you like to achieve with therapy Und was für nes Ziel? (0.8) Was möchteder erreiche mit de Therapie
B16 PTe Rx1_16.10	.hh What is your goal here for the therapy .hh Was isch üches Ziel do vu de Therapie
G05 PTk Rx1_13.16	What- what do you (.) expect (.) from physiotherapy? °what do you expect from me?° Was- was erwarte (.) sie (.) vu de Physiotherapie? °was erwarte sie vu mir?°
***Wh*-question in the beginning of the second consultation**	
B10 PTg Rx2_4.29	What do you expect from the therapy at the moment. what is your goal. what would you like to achieve. Was erwarten sie von der Therapie this time. was ist Ihr Ziel. was möchten Sie erreichen.
B08 PTd Rx2_10.04	.hh And what is your goal? (.) what would you like to be able to do again if this- .hh Und was isch eues Ziel? (.) was möchteder wieder mache nächher wenn das-
Abbreviated *wh*-question – at the end of the information-gathering phase	
B09 PTe Rx1_20.22	Your goal? (.) Mister X? (0.3) here in therapy. Üches Ziel? (.) Herr X? (0.3) do ide Therapie.
B03 PTc Rx1_22.34	So your goal or your expectation for physiotherapy [...] (1.6) your goal or your expectation Aso eues Ziel oder eui Erwartig ad Physiotherapie [...] (1.6) eues Ziel oder eui Erwartig
B20 PTc Rx1_23.39	And (.) your:: go:::al ↑now or your expectation for physiotherapy? And (.) Eues:: Zi:::el ↑jetzt oder Eui Erwartig ad Physiotherapie?
YNI – during intervention phase	
B17 PTb Rx1_34.04	Do you have a certain ↑goal? (.) in ↑mind? Heiter es bestimmts ↑Ziel? (.) vor ↑Auge?

Legend: *wh*-question = a question formed with an interrogative word (what, when, where, etc.); YNI = Yes/No-Interrogative; question that expects a Yes or a No as an answer

4.3. Discussion

Physiotherapists discuss goals and expectations with patients in various ways. In approximately half of the cases of my data (15/28) physiotherapists do this by posing direct questions about goals. The cases in this chapter indicate that even though goal discussions most frequently take place at a juncture between the history-taking phase and the physical examination, this is not necessarily the only point at which goals can/should be discussed. I described the different ways that physiotherapists topicalise goals in consultations. Most commonly physiotherapists use either a *wh*-question of the following types: *What is your goal? What do you expect from physiotherapy? What would you like to achieve?* (11/15), or an abbreviated version of the *wh*-question (3/15). In one episode, the therapist uses a Yes-No-question. I was able to illustrate that therapists treat goal discussions as a separate topic of investigation. They do that by closing down the previous topic before initiating the goal enquiry. The findings also demonstrate how therapists treat goals as separate entities existing in patients' head prior to any question asked about them. Physiotherapists build assumptions into their question: (1) Patients have a goal that is acceptable for physiotherapy, and (2) patients are able to articulate those goals.

In this section I present the implications of these findings. I discuss the consequences of conceptualising the goal setting as an independent activity. Furthermore, I focus on specific features of the question design as they are played out in the interactions. This will be followed by a discussion about the dimensions of question, including epistemics and preferences. I then highlight the interactional work that is required during goal discussions when assumptions are not shared or mutually oriented to.

In Section 4.2.1 I showed that physiotherapists treat the goal enquiry as a separate action. In most cases, therapists introduce goal setting as a stand-alone topic after having closed down the prior topic both vocally ("*good*" – Extract 4.4; "*exactly*" – Extract 4.2) and in an embodied way (documenting in chart, gaze shift and body movement – Extract 4.3). This topic shift gets accomplished collaboratively as shown by

prior studies by orienting to modalities such as talk (Schegloff, 2007a; Beach, 1993), body movement and gaze (Robinson and Stivers, 2001). Yet, my findings further indicate that those features do not only hold true in medical settings and in an English-speaking environment, but also in my setting of physiotherapy in a German-speaking context.

When therapists enquire about goals, they pose questions that have some signs of a routine character (*and*-prefaced, Extract 4.5 and 4.9). Yet, it is evident in the interaction that the nature of the question about goals is received differently by patients than questions about employment status or doctor's appointments. While questions regarding employment status (Extract 4.5) and doctor's appointments (Extract 4.8) seem regularly to be answered without hesitation, the enquiry about goals resulted in some instances in interactional difficulty (Extract 4.7 and 4.8). I argue that this might be due to the fact that those previous questions on employment etc. are part of the patient's knowledge/domain. When patients are required to answer questions with regard to their goals, problems arise when they orient to having less knowledge and to being less certain about what would constitute an apposite response. When therapists enquire about goals as a new topic, those goals are oriented to by therapists as concerning the same type of knowledge as in the foregoing enquiries, yet it is not always treated the same way by patients. I further explore this topic in Chapter 5.

In my data, *wh*-questions are commonly used to enquire about goals. As we have seen in the introduction, questions in institutional and non-institutional settings have been studied extensively (Heritage, 2010; Heritage and Clayman, 2010; Heritage, 2013; Stivers, 2010; Stivers and Enfield, 2010). Many of the features described in the literature that help mobilise a response are present in my data. Initiating the new topic, i.e. the goal enquiry, by in-breath, rising intonation and coordination between talk and gaze help mobilise a response (Schegloff, 2007a; Heath, 1992; Robinson and Stivers, 2001). Several features of turn design can help mobilise a response: grammar (interrogative morphosyntax, i.e. the way words are put together in phrases or sentences), interrogative intonation (prosody), recipient epistemic expertise on the topic relative to

the speaker, and gaze to the recipient (Stivers and Rossano, 2010). Several of the described elements to mobilise a response are recurrent in my data: *wh*-question (14/15 episodes), epistemic stance and gaze.

My data illustrate that the goal enquiry using a *wh*-question is treated by the physiotherapist as requiring a response, and if the response is not forthcoming, the action will be pursued (extract 4.10). If this pursuit becomes prolonged, the action will be accounted for (Extract 4.11).

The epistemic dimension is described as an important aspect of questions (Heritage and Clayman, 2010). There is evidence in my data that when physiotherapists ask a *wh*-question, they tend to start off using a formulation which implies they themselves have little knowledge of the goal (Heritage and Clayman, 2010). In the physiotherapy context, the question "*what is your goal?*" (Extract 4.5 - line 13) implies that the questioner (the physiotherapist) does not claim any knowledge about goals and also that the patient *does* have this knowledge, thus in terms of an epistemic gradient, the patient is treated as well above the therapist in this matter. Depending on the patient's response, therapists may reduce the epistemic gradient by proposing a goal (e.g. Extract 4.3, line 30 – "*for example to make the beds faster or what?*") and thereby make the choice more restricted for the patient. I highlight that this shift from a less to a more knowledgeable position (Heritage, 2013) can only be achieved if the physiotherapist has gained some knowledge earlier in the consultation. For instance, in Extract 4.3 where the goal enquiry takes place in the beginning of the second consultation, the therapist can draw on knowledge previously discussed with the patient (and written down in the chart). In goal enquiries that take place in the beginning of the first consultation and where the therapist and patient have exchanged less information, the epistemic gradient is not reduced (Extract 4.5 and 4.11). While in the first case the patient voluntarily provides sufficient information, in the second case (4.11) the therapist has limited possibilities to formulate a question with a shallower epistemic gradient because s/he has such limited prior knowledge of the patient. Asking about the

goal in the beginning of the first consultation, then, provides the therapist with less room to adjust the epistemic gradient (Heritage and Clayman, 2010), because the therapist has less information upon which to formulate candidate goals fitted to the patient.

A second dimension of questions is the previously discussed matter of "preference". I argue that dispreferred responses in my data are mitigated with "*jo*" (translated as "well"), as shown in several extracts (Extract 4.7, Extract 4.9). However, Schegloff and Lerner (2009) suggest that preference terminology might not be appropriate for *wh*-question analysis, but preference terminology draws the attention to the non-straightforwardness of a response. They claim instead that the focus should be on the analysis of "opposing pairs of action types (like agree/disagree)" and turns should be examined using the terminology of straightforward/non-straightforward (Schegloff and Lerner, 2009; p. 113). In that sense, the *well*-prefaced responses in my data can be considered "sequence-conforming responses" (Schegloff and Lerner, 2009). I claim, supported by my data, that goal setting in physiotherapy is not a straightforward activity. My data show that *wh*-questions can create interactional difficulties and that participants have to remedy these difficulties before they can progress with the talk. The next chapter will further explore this aspect when illuminating patients' responses to the goal enquiry.

As well as matters of epistemic dimensions and preference, assumptions embedded in the questions (Heritage and Clayman, 2010) are of interest in my study. In smooth or straightforward interactions physiotherapists' questions and patients' responses display the same assumptions. In more lengthy interactions, with more steps and negotiations, hitches and so on, patients do not respond to therapists' initial enquiries in a straightforward manner. Several interactional features in my analysis have illustrated difficulties, made evident by participants through: laughter (Extract 4.7), delays (Extract 4.8, 4.9), claims of no knowledge ("*no idea*" - Extract 4.7; "*I don't know*" – Extract 4.10), as well as accounts from the patient for not responding in a type

conforming way (Extract 4.7). The latter example illustrates how the physiotherapist accounts for her goal enquiry as she continues to pursue a response via an extended questioning sequence (Extract 4.9 – 4.12).

One way of remedying the misalignment between patient's responses and the expectation embedded in the therapist's question is provision of an account (Extract 4.9 – 4.11). In this episode, the therapist gave a detailed rationale about the definition of precise goals or, put another way, a rationale for why an interactionally adequate answer is not treated as contextually adequate.

The findings of this chapter provide insight into goal setting as they explicate some of the interactional features of question designs and their dimensions, as well as the underlying assumptions embedded in therapists' questions and the consequences when those assumptions are not mutually oriented to by patient and therapist. In the next chapter, I focus on patients' responses to the goal enquiry and what can be understood with regards to how knowledge about goals is conveyed in the interaction.

Chapter 5: Epistemics in interactions: Responses to physiotherapists' enquiries about goals

5.1. Introduction

In the previous chapter, I showed how physiotherapists topicalise goals for physiotherapy by posing patients a question of the type "*what do you expect from physiotherapy?*" I identified the locations at which the goal enquiries occur and pointed out the assumptions embedded within therapists' questions. I showed that most of the goal enquiries in my data are formulated as *wh*-questions (14/15). The 14 cases included in this chapter are initial responses to those questions.

In this chapter, I move on through the sequence by examining patients' responses to the therapists' *wh*-questions. It turns out that understanding issues of both access to and authority over knowledge, and entitlement with regard to formulating a goal, are central to understanding goal setting practices in physiotherapy. First, I provide an overview of the interactional literature on epistemics and evidentiality, followed by an overview of studies on responses to *wh*-questions. I then move to analysis: first, I analyse examples without apparent interactional difficulties and where there is immediate acceptance of the patient's response by the therapist; second, I examine sequences with a less than straightforward response. I show how physiotherapists' assumptions – that patients have goals and that they are able to articulate them – are sometimes aligned with, from the outset, by patients, while at other times, participants negotiate their responsibilities and right to know about goals during the interaction. In the final section of this chapter I review my findings and examine what they mean for goal discussions in the context of physiotherapy.

The analysis in this chapter indicates that even though physiotherapists' questions assume that patients know what their goals are, patients demonstrate in their responses different degrees of certainty about this knowledge. In this chapter, I will focus first on five goal setting sequences in which patients produce straightforward responses that are subsequently treated by therapists as apposite goals, and nine

sequences where patients respond in a less straightforward manner and display some troubles in responding to the goal enquiry. Patients face the challenge of doing interactional work while attending to a difference in status (their own experience vs. professionals' status). They do so by using various interactional resources that convey their epistemic stance and that indicate different resources (i.e. knowledge about their body or knowledge about physiotherapy). As part of my examination of interactional resources utilised by patients, I show that they use the German modal particle "*einfach*" (standard German vs. "*eifach*" or "*eifacht*" in Swiss German, translated approximately as "*just*") to indicate that they treat themselves as entitled to state a goal that is in their domain (knowledge about their body). Yet, at the same time they sometimes downplay their claim using *jo*-prefaces (translated as *well)* and tag questions and thereby accept the therapists' authority with regard to their physiotherapy knowledge (knowledge about bodies in general, physiology and pathology). While patients display knowledge about their own bodily experiences, therapists possess professional expertise about how bodies function and how problems with body structure occur and evolve. Using their aforementioned resources, patients attend delicately to the epistemic differences between therapist and patient. It seems that source-based authority (based on patients' experience) is oriented to as subordinate to status-based authority (physiotherapy knowledge). Through the evidential marker "*I think*" patients convey limited entitlement to making claims about goals. Authority, status and entitlement are inherent to the concept of epistemic access and primacy, so they are reviewed in the next section.

5.1.1 Rights and responsibilities of knowledge

In this chapter I look at how knowledge is displayed by participants and what type of interactional resources are used to indicate rights and responsibilities with regard to knowledge about goals. Stivers, Mondada and Steensig (2011) define knowledge as "dynamic, graded and multidimensional" and argue that "epistemic resources are normatively organized" (p. 3). Knowledge is not fixed but enacted within social and interactional constraints. Knowledge cannot be examined directly, but can be made evident through investigation (Bergmann and Quasthoff, 2010). While it has been

argued that knowledge cannot be conceptualised as a mental process, but as a social practice (Loftus, 2006), detailed empirical examinations of the management and constitution of knowledge in interaction have only recently emerged (Heritage, 2012a and 2012b; Stivers et al, 2011; Dausendschön-Gay, Domke and Ohlhus, 2010).

Participants negotiate their rights to knowledge and information during interactions (Heritage and Raymond, 2005). Knowledge can be owned or shared, and is treated "as an object over which authority can be disputed" (Koole, 2010; p. 186). Participants can and do hold co-participants accountable with regard to epistemic rights and responsibilities. For the purpose of this chapter, it is useful to highlight some key issues: epistemic access, authority (epistemic primacy) and evidentiality.

First, the term epistemic access refers to the speakers being careful about making claims when they suspect that co-participants have better access to or knowledge of some state of affairs (Heritage and Raymond, 2005). The following extract is an example in which the therapist asks the patient about her occupation (lines 1 – 3) and employment status (lines 8 – 9) and to which the physiotherapist does not claim to have access.

<u>B04 PTd Rx1_6.58 (simplified transcript)</u>

1 Physio U::hm (.) what do you do professionally?
2 (0.2)
3 Patient I am a registered nurse

A few lines omitted – therapist writes in chart

8 Physio .hh What is the percentage of employment then.
9 Patient Eighty percent

Downgrading the degree of access the speaker claims is done by the use of specific interactional resources (e.g. tag questions). Tag questions may help fine-tune rights to knowledge (Hepburn and Potter, 2011) and modulate/defer the right to know to the other participant (Heritage and Raymond, 2005). With these resources one person can attribute epistemic access in the matter to the co-participant, which is important

when patients treat physiotherapists as more knowledgeable about goals. Additional resources include modal particle (e.g. "*eifach*" - translated with "*simply*" or "*just*"), which can add authority to a claim. Patients indicate through this particle that they treat the goal as knowledge pertaining to their domain, but at the same time recognise the professional's authority. It is a way for the patient to manage the constraint of the question and the certainty about the goal.

Second, epistemic authority refers to which participant has more knowledge relative to the other person. It is expressed by participants in a way such a way that speakers with more detailed and in-depth knowledge have primary rights to make assertions and assessments regarding this domain (Stivers, Mondada and Steensig, 2011; p. 14). The following example (from the French data corpus, see Schoeb et al, 2013) shows clearly how the patient refers to the physiotherapist being the one to know.

HO 02 PTr Rx1_9.05

1 Physio	.hhhh And then what are your expectations for the treatement here [at-]
2 Patient	[Well]=
3	=after having tried the-the- the Chinese acupuncture uhhh after having tried the (.) even a healer
4	(0.3)
5 Physio	↑Mhm
6 Patient	Uhh I- I- somebody told me (.) that somebody- they told me that I need a warm pool and the only warm=
7	=pool is [here]
8 Physio	[Alright] so you would like to try the warm [water]
9 Patient	[Oh really] I came here- well [I entrust] to the=
10 Physio	[Yeah]
11 Patien	=technicien (.) [of this]
12 Physio	[Yeah yeah] alright.

In my data, epistemic authority is oriented to in a more subtle way. Evidential markers such as "*I think*" or "*probably*" can be used to downgrade assertions and indicate uncertainty about the knowledge. Downgrading of an assessment using those interactional devices helps avoid making claims that the person is not entitled to (Heritage and Raymond, 2005). Yet, entitlement is negotiated by the participants through various linguistic means and is not a predefined category (Asmuss and Oshima,

2012). Enfield (2011) talks about source-based authority, which is knowledge based on experience and status-based authority (what a person is entitled to know). The source-based authority is at stake when for example patients can actually cite their own (direct) experience and are therefore certain to know about it. In contrast, the status-based authority it is not that much about what a person knows, but what they are supposed to know. According to Enfield (2011) "source-based and status-based authority are typically in alignment" (p. 301), yet I show that sometimes they are not.

Third, related to epistemic access and authority is the concept of evidentiality. Evidentiality describes the way that speakers index the degree of reliability of their knowledge by indicating the source of information (Clift, 2006). Clift differentiates between "stand-alone" evidentials (such as "*I think*", "*according to…*"), which serve to "calibrate the speaker's accountability with regard to the truth of what is said" and the interactional evidentials (related to sequential positioning such as reported speech) indexing the "relative authority of the speaker over a co-participant with respect to what is said" (p. 583). In the analytic section (5.2.4) I show how evidentiality is linked to epistemic authority and how evidential markers such as "*I think*" are resources to enact epistemic matters.

Epistemic access and authority can be assessed according to their congruence between participants (Hayano, 2011). An interaction is epistemically congruent when there is apparent agreement on who has (or does not have) access to or authority over the information (Stivers et al, 2011). Displaying epistemic rights and responsibilities means that participants express their social relationships, and manage access to and authority over knowledge through the "design of turn at talk" (Heritage, 2012a; p. 6).

This chapter presents the analysis of 14 cases of patients' responses to a question of the type "*what is your goal*" or "*what do you expect from therapy?*". Before entering the analytic section of this chapter, I provide an overview of the current literature on responses to *wh*-questions.

5.1.2 Responses to *wh*-questions

The literature on questions and responses has so far focused mainly on Yes/No-interrogatives, particularly in healthcare interactions (Raymond, 2010; Heritage, 2010). Only a few studies have investigated responses to *wh*-questions, and those mainly draw on ordinary conversational rather than institutional data. Compared to everyday conversations, institutional talk is more restrictive in terms of participants' interactional contribution (Heritage, 2004). With this limitation in mind, I summarise some key studies relevant to the topic at hand.

Research suggests that there are different interactional features identified, depending on whether responses are straightforward or not. One way of looking at this, and which is relevant to my data, is to look at how responses are initiated. An analysis based on ordinary interaction indicates that *well*-prefacing introduce responses which are less than straightforward (Fox and Thompson, 2010; Schegloff and Lerner, 2009). The "*well*" in turn-initial position of the second pair part (i.e. patient's response) serves "as an alert to the questioner that the response will be in some respect not straightforward, and that it should therefore not be parsed as such, but rather requires attention to the ways in which it is not straightforward to allow a proper understanding" (Schegloff and Lerner, 2009; p. 101). This interactional feature is also confirmed in German conversations. It is argued that "*ja*" in turn-initial position resists a question's term and alerts the recipient that the answer is insufficient or vague (Barske and Betz, unpublished). Even though "*ja*" does not seem to have the same function as "well" it shows a disprefered response to the *wh*-question.

In this background section, I covered aspects that will prepare the scene for the analysis of my data: a) epistemic rights and responsibilities and how they are managed through the expression of epistemic access and authority (epistemic primacy); and b) what do we know about responses to *wh*-questions. In the following findings section, I present evidence that physiotherapists' assumptions – that patients have goals and that they are able to articulate them – are sometimes shared from the outset by patients, while at other times, participants negotiate their responsibilities and right to knowledge

and information during the interaction. Patients' responses to goal enquiries can be placed on a continuum in terms of knowledge in interaction. On one end there is the goal setting process in which patients respond straightforwardly and align with the assumptions embedded in the question (Section 5.2.1). In those cases, patients claim knowledge about their body, especially in terms of physical abilities. On the other end of the continuum there is the no knowledge claim indicating that patients do not treat themselves as they have or should have knowledge about goals (Section 5.2.5). The middle ground is occupied by the goal setting process in which patients use interactional resources to convey different degrees of certainty about their knowledge (*well*-preface and tag questions - Section 5.2.3), indicate their level of entitlement through the use of evidential markers ("*I think*" – Section 5.2.4) or display their authority ("*eifach*" – 5.2.3).

By using the modal particle "*eifach*" or the evidential marker ("*I think*") patients indicate their epistemic stance in terms of authority and entitlement, thereby maintaining the moral order. Peräkylä (2002) argued that in medical interactions, authority is part of the doctor's relationship to the patient, and medical doctors are entitled to know more about the medical problem than patients. Through demonstration of inferior entitlement to knowledge the patient maintains the moral order (epistemic authority). Heath (1992) was able to show that patients maintain a distinction between their own conception and knowledge about their health problem and the doctor's expertise.

In sum of this chapter, I introduced two elements of epistemic stance, one related to epistemic access (to what knowledge about goals and physiotherapy have patients access to) and the other concerning authority/entitlement (how patients treat themselves as being entitled to tell therapists about their goal). The therapists' questions assume that patients have the knowledge to be able to formulate a goal in their own minds, and that they have already done so a priori. In addition, the therapists' questions embed the assumption the patient will straightforwardly treat themselves as entitled to tell the therapist their goal. In Section 5.2, I show how participants in a

physiotherapeutic setting negotiate epistemic rights and responsibilities during the goal setting activity, which is not predefined in advance, as assumed by therapists, but co-constructed on a turn-by-turn basis during the interaction.

5.2 Findings

In the first part of this findings section, I present examples of goal discussions in which patients respond in a straightforward manner (5/14 cases). Patients commonly respond to the physiotherapists' enquiry with "*that I can do x again*" claiming knowledge about goals. The type of knowledge in the straightforward cases is often linked to a goal pertaining to the knowledge about their bodies or physical abilities (e.g. to be able to run again, go back to work, etc.). The five cases can be categorised as epistemically congruent, as there is apparent agreement between patients and physiotherapists about who has access to and authority over the formulation of goals, and therapists almost immediately accept the patients' goal proposal.

Second, I examine cases in which participants' epistemic stances are not necessarily compatible. When patients make reference to a different type of goal, unrelated to knowledge about their bodies, they tend to reduce their certainty for knowing such a goal. They respond to physiotherapists' goal enquiry by using impersonal pronouns ("*it loosens up*") or by presenting a request for instruction of fitness equipment ("*that you show me the fitness equipment*"). In these cases, patients treat their knowledge about goals as inferior and use interactional resources (e.g. *well*-prefacing in 7/14 cases; tag questions – 3/14; silences) to indicate their epistemic stance and attribute authority to the physiotherapist. Finally, there is one case in which the patient claims not to have a goal to suggest.

Third, I focus in upon two of the practices through which patients convey and construct epistemic stance. I explore the use of the modal particle "*einfach*" (7/14 cases) and the evidential marker "*I think*" (3/14). Using those two discourse markers, patients negotiate in a subtle way the distribution of knowledge (who is entitled to what type of knowledge) and authority over the matter.

5.2.1 *"That I can go back to work fully"* – A straightforward response to the goal enquiry

In 5/14 cases patients' initial responses to the goal enquiry are straightforward, providing a short answer of the type "*that I can do x again*" and invoke a matter that is treated by the therapists as a goal. In the following examples, I show that in straightforward responses patients commonly include "*again*". With this adverb patients make reference to the fact that they were able to do the activity before the illness/problem started or got worse. In doing so, they imply that patients are aware of what physiotherapy can do and help and, therefore, know that the nature of the goal they are being asked about has to do with physical abilities about which they are the experts. In that sense, this straightforward response "*that I can do x again*" shows us that a) patients formulate their goals based on their body experience, and b) patients who employ "*again*" orient to the fact that they know about what physiotherapy can restore (namely function and physical abilities). The following examples are chosen in order to illustrate those points.

In Extract 5.1 the patient is seeing the therapist for a neck problem; she suffers from dizziness and nausea related to her whiplash injury in a car accident.

Extract 5.1.B10 PTg Rx2_4.22

8 Physio	Die nächste Frage ist ↑die (.) was erwarten sie von der Therapie im Moment.
	The next question is ↑this (.) what expect you from the therapy at the moment.
	The next question is this one (.) what do you expect from therapy at this time
9	was ist ihr Ziel. was möchten Sie erreichen.
	was ist your goal. what would like you to achieve.
	what is your goal. what would you like to achieve.
10	(0.9)
11 Patient	Dassi mini Bewegige wieder cha mache
	That I my movements again can make
	That I can move again
12	(2.0) *((physiotherapist is writing in his chart))*
13 Physio	Ihre Bewegungen das heisst?
	Your movements that means?
	Which means that you can move again?
14	(0.2)

15 Patient Auso dass mer ned immer wieder schwindlig wird

So that me not always again dizzy get

So that I don't get dizzy all the time

16 (0.7)

17 Physio **↑Mhm**

18 (1.4)

The patient responds in a straightforward manner ("*that I can move again*" - "*dass ich mini Bewegige wieder cha mache*" – line 11) emphasising "movements". This response is straightforward as it is uttered without delay and without variations in pitch (at the beginning or the end of the turn). It can be considered a type conforming response (Raymond, 2003), in that it is fitted to the terms of the question. Sequentially, the therapist takes it up as an acceptable goal by writing it in his chart (line 12).

To corroborate the argument that straightforward responses share a common format of the type "*that I can do x again*" and are subsequently accepted by therapists, I present the next example. Extract 5.2 is also consistent with the previous extracts in regard to the patients' goals based on knowledge of their body but it differs in that the physiotherapist is not only non-vocally accepting the goal (writing) but also verbally doing so.

The patient is consulting this therapist after a work accident (he works as a butcher). Having broken his clavicle, he was wearing a stabilising device for 6 weeks, and he is now allowed to gradually build up strength and mobility. In line 9, the physiotherapist enquires about the goal; the enquiry is then answered in a straightforward manner by the patient.

Extract 5.2: G02 PTn Rx1_00.18

8 Patient Ich möchte mich gerne behandlen lass[en]

I would me like to treat le[t]

I would like to be treated

9 Physio [↑Ja] (.) und was ist das Ziel.

[↑Yes] (.) and what is the goal.

10	(0.9)
11 Patient	Dass ich wieder voll arbeiten gehen kann
	That I again fully work go can
	That I can go back to work fully
12	(0.6 – *therapist looks down to chart, turns it and prepares to start writing)*
13 Physio	Das isch es schöns Ziel
	That is a nice goal
	This is a good goal
14 Patient	Ja
	Yes

The patient provides a straightforward answer to the 'what is the goal' question emphasising "*I*" and "*work*" ("*That I can go back to work fully*" - line 11). The therapist's response "*This is a good goal*" (line 13) is an assessment of the patient's goal[41] which underlines the fact that the therapist treats the patient's straightforward response as an apposite goal. Minimal delay and no hesitation indicate the participants' epistemic congruence.

The two examples presented are similar in the way the responses were formulated. Both responses use the formulation starting with "*that I can…*". Extract 5.1 and 5.2 include pronouns ("*I*") referring to themselves, action verbs ("*can move*" – "*can go to work*") as well as items linked to the verb ("*again*" – "*fully*").

The next Extract 5.3 supports the argument that responses to *wh*-question are fitted to the physiotherapist's enquiry by presenting a type of knowledge related to his/her body. The patient comes to see the physiotherapist for a knee problem. She is a leisure runner (running distances of 10 kilometers) but is unable to do so now because of pain. As in the two previous examples, the proposed goal is related to her physical abilities (knowledge of her body). In all the extracts so far, patients are able to express their knowledge about goals as they describe a goal related to their physical difficulty. They also treat themselves as being entitled to know the goal and as having the authority

[41] The assessment « this is a good goal » is rare in my data, but conveys an evaluative stance towards the patient's goal statement. Although it would be interesting to analyse this moral work throughout the interaction, this is not the topic of this chapter.

to do so. The particularity of this extract is the patient's responses starting with "my goal is…", thereby repeating the therapist's question and indicating her understanding about goal setting.

Extract 5.3: B04 PTd Rx1_6.58

13 Physio	E:::::hm (.) J:a und was isch dis Ziel?
	U::::hm (.) Ye:s and what is your goal?
14	(0.5) ***((****Physiotherapist looks at patient))*
15 Patient	Mis Ziel isch dass ich wieder cha go jogge so wienich körperlich au ↑mag
	My goal is that I again can go to jog like the way I physically also ↑be able
	My goal is that I can go running again as much as I am physically able to
16 Physio	**↑Mh[m]** ***((****Physiotherapist writes in chart))*
17 Patient	[o]hni dass mi de Schmerz behinderet
	[wi]thout that me the pain handicapped
	without being bothered by the pain
18	(2.1) ***((****Physiotherapist continues to write in her chart))*

The patient's repeat ("*my goal is*" - line 15) emphasises "*goal*" in the same way as in the therapist's question. The goal description is formulated using a structure similar to the ones seen in Extract 5.1 and 5.2 ("*that I can go running again*"). Additional emphasis in the patient's answer is put on the verb "*running*". The difference from the previous two cases is that the patient in Extract 5.3 is expanding on it by conveying enough knowledge about what physiotherapy can offer, namely restoration of function, not necessarily better performance ("*as much as I am physically able to*" - line 15). The increased pitch at the end of line 15 shows that the patient's turn is not finished yet. The physiotherapist's minimal *"↑Mhm*" with a rising intonation (line 16) encourages the patient to continue, and the patient finishes the turn with the second part of the goal statement (line 17 – "*without being bothered by the pain*"). The physiotherapist writes the information in her chart accepting the patient's goal and treating it as worth documenting.

The three examples show how patients answer the goal enquiry in a straightforward manner. So far, I have shown that straightforward responses to the goal enquiry are uttered with minimal delay and take the form: "*that I can do x again*". The

response is ratified by the therapist either vocally ("*this is a good goal*" – Extract 5.2) or embodied by writing down the goal in the chart. Assumptions underlying the goal enquiry are maintained in those interactions: that the patient has a goal and is able to articulate it (see Chapter 4), that goals are in a sense owned by the patient and that the patient has the knowledge (about his/her body and about what physiotherapy can offer) to provide a response and treats him/herself as entitled to express that knowledge (Chapter 5). The examples demonstrate that the participants' epistemic assumptions are compatible and thereby epistemic congruence is achieved. A "no trouble response" is the outcome.

Yet, answers are not always straightforward, and interactional resources are used by patients to convey uncertainty about knowledge claims and to attribute authority to the therapists. I demonstrate in the next section that patients convey epistemic stances that do not fit with the therapists' assumptions that (1) patients have access to knowledge/information about a goal, and that (2) they straightforwardly treat themselves as entitled to that knowledge. I describe what practices patients use (*well*-prefacing and tag questions) as a way to show that they do not feel entitled to propose a goal.

5.2.2 Conveying uncertainty about goals: *well*-prefaces and tag questions

Well-prefaced responses to *wh*-questions have been defined as demonstrations of minor troubles in non-institutional conversations (Fox and Thompson, 2010) or as interactionally problematic for participants (Schegloff and Lerner, 2009). Even though no research has been done on those issues in Swiss German, a lay sense of the particle "*jo*" indicates hesitation in the beginning of a turn. "*Jo*" is literally translated with "*yes*" but has most often a meaning of "*well*" in this context. Conversation analytic work describes that the German "*ja*" (in English "*yes*") in single-turn or in turn-initial positions functions as a continuer or "as an acknowledgement token through which its producer claims understanding and/or agreement with a prior turn" (Golato and Fagyal, 2008; p. 247). Recent unpublished work indicates that "*ja*" in turn-initial position resists a question's term and alerts the recipient that the answer is insufficient or vague (Barske and Betz,

unpublished). Apart from "*jo*" patients use the particle "*aso*", which can also be translated as "*well*". In my data, a delayed onset is quite often associated with the *well*-preface which is in line with prior research (Goodwin and Heritage, 1990). I am aware that more detailed conversation analytic work is needed to understand the potentially different function of "*jo*" and "*aso*", yet for the purpose of this chapter I dare to put forward the analogy between the German particles "*jo*" and "*aso*" and the English "*well*".

In Extract 5.4 I would like to draw attention to two things: the delayed onset of the patient's response (pause of 1.7 seconds - line 18), which is then followed by the patient's *well*-prefaced response (line 19) as well as the type of knowledge presented. It is also important to note that this patient who is suffering from chronic back pain attended an intensive 3-week-programme at the inpatient unit of the same hospital a few years earlier. We could therefore assume that she be expected to have access to quite a bit of knowledge about physiotherapy and what a reasonable goal would be for therapy. In addition to that, she had already worked with the same therapist. The therapist acknowledges this fact by adding "*now*" to the goal enquiry, thereby making reference to the patient's prior experience (line 17). This episode is therefore an example in which epistemic entitlement is negotiated in interaction.

Extract 5.4: B20 PTc Rx1_23.22

17 Physio	ts .hhhhhh (.) Und (.) Eues:: Zi:::el ↑jetzt oder Eui Erwartig ad ↑Physiotherapie?	
	ts .hhhhhh (.) And (.) your:: go::al ↑now or your expectation for ↑physiotherapy?	
18	(1.7) *((Physiotherapist looks at the chart until the end of the pause, then looks up))*	
19 Patient	Jo dass mer eifacht löst ↑irgend[wie] (.) >wenns de eifach- <	
	PART that me MOD loosen ↑some[how] (.) >if it does then MOD-<	
→	***Jo*[42] that it *eifach*[43] loosens up again somehow (.) if it *eifach*[44]-**	
20 Physio	**[↑Mhm]** *((Physiotherapist starts writing in chart))*	
21	(1.7) *((Physiotherapist writes in chart))*	

[42] Approximate translation: "*well*"
[43] Approximate translation: "*just*"
[44] Approximate translation: "*simply*"

22 Patient	dass es eifacher ↑wird
	that it easier ↑will be
	that it will become easier
23	(3.8) *((Physiotherapist writes in chart))*
24 Physio	**↑Mhm**
25	(6.3) *((Physiotherapist writes in chart))*
26 Physio	Bi wellne Aktivitäte stört Euch denn das Problem im Moment am meischte=
	With which activities bothers you then the problem at the moment the most=
	In what activities does the problem bother you the most this time
27	woder säged (0.6) das möchti wieder besser chönne mache?
	that you say (0.6) that would like I again better could do?
	about which you say (0.6) I would like to be able to do that better again?

The patient starts with "*jo*" ("*well*" – line 19) before continuing with a "*that*"-clause. Not only does the patient use a *well*-preface, but she also uses an impersonal "*it loosens*", which contrasts with the formulation "*that I can do x*" shown in straightforward responses: *" that it* eifach *loosens up again* ↑*somehow* (.) *if it does then* eifach-" (line 19). The use of the impersonal "*it*" (line 19 and 22) can be an expression of that the speaker takes a more distant stance (Reilly et al, 2005). Yet, as this formulation is a rare occurences in my data, it cannot be considered a consistent feature of the response design. The patient then continues but cuts off the utterance and formulates another "*that*"-response after a silence of 1.7 seconds (line 21). The last word of the turn is uttered with a rising pitch ("↑*wird*" – line 22) seeking confirmation from the therapist (Schegloff, 2007a). This confirmation is given in an embodied way by the therapist (line 23 – therapist writes in chart). During this exchange the physiotherapist's acknowledgment tokens ("↑*mhm*" – line 20) encourage the patient to continue. The key point in this extract is that the patient treats responding to the goal enquiry in a less than straightforward manner, using *well*-prefacing, pauses and the impersonal pronoun. It can be argued that she does not treat herself as entitled to state a goal, even though she has experience with physiotherapy and should therefore have an understanding of what physiotherapy is all about.

The next example shows how the patient uses an account in addition to the delayed onset of response and *well*-prefacing in order to indicate that her response is less than straightforward. The patient accounts for her goal with a long account of the reason for her request. Accounts usually indicate some kind of dispreference, providing justification of the action (Sidnell, 2010).

The type of knowledge presented about goals is different from what we have seen so far. Instead of describing a physical problem, the patient first states that she would like to know what she can do, thereby claiming not having access to the required knowledge. She continues by expressing a desire to have the physiotherapist explain some fitness equipment to her, which is a tricky business as this might be rather in the physiotherapist's domain. The resource used here by the patient is a tag question which has a similar function as the upwards intonation (Schegloff, 2007a) in the previous extract (line 22). Tag questions[45] can also help participants downgrade an assessment (Heritage and Raymond, 2005).

The patient comes to see the physiotherapist after back surgery (discectomy). She has suffered from chronic back pain for years and since the surgery the pain is much reduced.

Extract 5.5: B03 PTc Rx1_22.34

1 Physio	Aso eues Ziel oder eui Erwartig ad Physiotherapie (.)	
	So your goal or your expectation for the physiotherapy (.)	
	So your goal or your expectation for physiotherapy (.)	
2	>dir heit gseit de Chraftufbau das isch der Uftrag vum ↑Arzt<	
	>you had said the force improvement this is the demand from the ↑physician<	
	>you said that the physician would like to have the strength improved<	
3	(0.5)	
4 Physio	E::::hm	
	U::::hm	

[45] Tag questions have other functions (Hepburn and Potter, 2011; p. 216), however, this is not directly relevant here.

5 (1.6)

6 Physio Eues Ziel oder eui Erwartig

Your goal or your expectation

7 (1.7)

8 Patient ↓Jo isch eifacht (.) dass i im Prinzip weiss (.) was i de au selber cha ↑mache [oder]

↓PART is MOD (.) that I in principle know (.) what I then also myself can ↑do [can't I]

_Jo_[46] it is _eifach_[47] _t_ that I know in principle what I can do by myself as well can't I?

9 Physio **[↑Mhm]**

10 (0.7)

11 Patient Ebe was ich vielicht au wett dass- eh (.) dass- eh dass der mir irgendwie d'Grät=

PART what I probably also would like that- eh (.) that- eh that you me somehow the equipment=

Ebe[48] what I probably would like as well is that- eh (.) that- eh that you would show

12 =würded ↑zeige [wo] de mol guet [wäred] ou (.) dass wenni de mol-

=would ↑show [that] then PART good [would be] as well (.) that when I then PART-

me somehow the equipment that would be _mol_[49] good later on as well (.) that when I then _mol_[50]-

13 Physio **[Mhm] [↑Mhm]**

14 Patient in Gluren heimmer jo au sone (.) Physio eh- mit eh- Fitnessstudio

in Gluren we have PART also such a (.) physio eh- with a fitness studio

in Gluren we have _jo_[51] as well such a physio eh- with a- fitness studio

15 Physio **↑Mh[m]**

16 Patient [dass] wenni dört go dass i eigentli:ch (.)

[that] when I there go that I actuall:y (.)

that in case I go there I would actually know

17 wüsst was i z'tue ↑hä [säg ich's emol] so

would know what I to do ↑would have [say I it once] like this

what I had to do let's put it that way

18 Physio **[↑Mhm]**

19 (0.6)

20 Physio **Mhm.**

The patient's response starts with a "*jo*" ("*well*" - line 8) followed by the use of "*that*" initiated response ("*that I know in principle (.) what I can do by myself as well*

[46] Approximate translation: "*well*"
[47] Approximate translation: "*just*"
[48] Approximate translation: "*thus*"
[49] Approximate translation: "*once*"
[50] Approximate translation: "*again*"
[51] Approximate translation: "*evidently*"

don't I?" – line 8). The "*that*" formulation does introduce a goal in the sense that the patient would like to get more knowledge; in addition, she states her wish about a specific physiotherapy intervention (explaining fitness equipment). This type of knowledge, including the choice of therapeutic interventions, lies commonly in the professional's domain. Tag questions help the patient to acknowledge this fact and modulate her request ("*oder*" / "*can't I*" – line 8). In Swiss German, tags are used as a resource to modulate the statement, in particular to convey uncertainty about it (Frey, 2010). This is consistent with Heritage and Raymond's (2005) claim that tags convey epistemic downgrading of the patient's response. The physiotherapist uses "*mhm*" in overlap with the end of the turn (line 9, 18) and at turn completion (line 15), which is commonly found in everyday conversations (Selbling, 1996).

The non-straightforwardness of the response (delay, *well*-prefacing) indicates that the patient does not treat the therapist's question as one that s/he is entitled to respond to as it includes a domain that would lie normally in the therapist's realm. By using an account and a tag question, the patient juggles between her entitlements to present a goal while requesting a specific intervention and thereby telling the therapist what to do. Starting in line 11 the patient's expansion of the turn includes a request that the therapist show her some fitness equipment. She starts with "*ebe*" (translated as "*thus*") making reference to the previous turn by indicating that this additional information should not be news for the physiotherapist (Pollet, 2006). By showing uncertainty ("*probably*" – line 11) about her request ("*I would like that*"), the patient is treating the professional as the more expert party and formulates her request as follows: "*what I probably would like as well is that- eh (.) that- eh that you would show me somehow the equipment that would be* mol *good later on as well (.) that when I then* mol-*"* (line 11 – 12).

This request is accompanied by an insert expansion "*in Gluren we have such a (.) physio as well eh- with a fitness studio*" (line 14). Insert expansions are resources that allow the speaker to deal with matters in order to enable the action of the second pair

part, in this case the response to the goal enquiry (Schegloff, 2007a). In lines 16 and 17 the patient completes the turn by accounting for her enquiry by explaining that it is important to get used to the fitness equipment before she can go to the local fitness centre.

To sum up, I show with this extract how both epistemic access and entitlement are played out in the interaction. While the patient explicitly states her having insufficient access to knowledge, she uses different interactional resources (tags) and accounts to balance the authority about and entitlement to knowledge towards the other participant.

In the previous examples, *well*-prefaces were used after a prolonged silence indicating some interactional trouble. The next Extract 5.6 shows, however, that delays do not always precede *well*-prefaces. *Well*-prefaces and tags can also occur without delay, yet the uncertainty about knowledge claim remains. Those resources indicate, in this case, that assumptions with regard to epistemic entitlement are not shared, and thus project epistemic incongruence. Those interactional resources therefore indicate that patients have to strike a delicate balance between asserting claims with regard to goals while at the same time attending to the professional authority. The difference between source-based authority (goals based on patients' experience) and status-based authority (professionals' knowledge) comes here into play (Enfield, 2011).

This juggling act can even be more explicit when the patient in the next example uses on one hand hedging (*well*-prefacing) and tags indicating that he downgrades his claim to knowing a goal, and on the other hand he strengthens his claim to the appositeness of the goal ("*that's clear, isn't it?*" – line 14). The patient in Extract 5.6 has just undergone surgery for his painful shoulders and sees the therapist a few days after discharge from the hospital.

Extract 5.6 B09 PTe Rx1 20.06

11 Physio	.h Üches Ziel? (.) Herr X	
	.h Your goal? (.) Mister X	
12	(0.4) *((Physiotherapist shuffles paper and looks up))*	
13 Physio	do ide [Therapie]	
	here in the [therapy]	
14 Patient	[Jo eifacht] (.) ganz schmerzfrei werde oder (.) [ganz klar] oder	
	[PART MOD] (.) totally pain free to become huh (.) [totally clear] huh	
→	***Jo eifacht*[52] to become completely pain free huh (.) that's clear isn't it**	
15 Physio		[Schmerzfrei] werde
		[Painfree] to become
		To become pain free

The physiotherapist initiates the goal enquiry by asking an abbreviated question "*Your goal?*". I argue in Chapter 4 that abbreviated questions have the same function as full questions of the type "*What is your goal?*". The patient's response in line 14 starts with a "*jo*" ("*well*") followed by "*eifach*" (line 14). Tag questions, as discussed previously, can be seen as confirmation seeking which the patient utters after his response "*oder*" (line 14 - *"huh"*). In overlap, the patient repeats "*totally*", followed by a tag (*"that's clear isn't it"*). By using a modified repeat ("*to become pain free*" – line 15) the therapist closes the turn down (sequence-closing thirds - Schegloff, 2007a), but also modifies it through the omission of "*completely*" (line 15).

What is particularly interesting in the presented example is that even though the patient somehow responds to the goal enquiry with minimal delay, there are indications that soliciting goals from patients is a juggling act. The patient demonstrates that he is knowledgeable about goals without claiming authority and uses, therefore, interactional devices such as *well*-prefaces and tag questions to indicate his entitlement. I argue that by using those resources patients convey their epistemic stance to the therapist and assist the participants in negotiating knowledge claims. Epistemic congruence requires compatibility of knowledge claims, including assumptions in regards to access of and entitlement to knowledge. I argue that the patient's response in Extract 5.6

[52] Approximate translation: "*well just*"

demonstrates that he orients to this goal as apposite. By indicating this goal as obvious ("*that's clear isn't it*"), the patient demonstrates that the goal presented cannot be challenged. The modal particle "*eifach*" has in fact a similar function (see Section 5.2.3). The physiotherapist's partial repeat in overlap "*to become pain free*" (line 15) functions as a confirmation. While partial repeats are used to do confirming – and therefore aligning to the action (Stivers, 2008) – they also emphasize the physiotherapist's claim to have primary rights to make an assertion (Stivers, 2005) shifting therefore the authority from one participant to the other. The omission of "*completely*" (line 14 presented by patient is not repeated in line 15) becomes significant in the negotiation of epistemic rights and responsibilities.

In this section, I was able to show that when patients respond to the goal enquiry, they do not always do so in a straightforward manner. They manage epistemic claims on a turn-by-turn basis. By using *well*-prefaces and tag questions patients indicate their subordination with regard to the entitlement of knowledge about goals. In a non-straightforward response patients initiate the turn with some kind of *well*-prefacing ("*jo*", "*aso*", "*ja*"), sometimes after a delay. The use of tag questions indicates that patients defer the right of knowledge to the therapist and thereby shifting the authority to the health professional. Yet, as shown in those previous examples, tag questions can both be used to either downplay the patients' knowledge claim, or as a device to maintain asymmetry within the interaction.

This shift in authority of knowledge is, however, a dynamic matter and plays out not just with interactional devices such as tag questions, but also with the use of the modal particle "*eifach*" which will be explored in the next section.

5.2.3 Use of the modal particle "*eifach*"

This section provides insight into the frequent use of both variations of modal particles "*eifach*" or "*eifacht*" (best translated as "*just*" or "*simply*"). I will demonstrate, through analysis of extracts, that these modal particles are deployed by patients when discussing goals to indicate that goals are in their domain (knowledge about their bodies). From a theoretical perspective, the speaker indicates with the modal particle

"*eifach*" that there is a simple, obvious explanation or justification (Pollet, 2006; p. 35). Up until the present, there is mainly linguistic literature on modal particles (in German "Abtönungspartikel"; Hartmann, 1986; Autenrieth, 2002; Wienerroither, 2009; Gutzmann, 2010) while interactional data of spoken conversation is rare. Modal particles are characterised as words that are inflexible, short, and unstressed (Hench, 2011). They fulfill different functions such as dividing a sentence into given and new information or indicating the speaker's attitude (Fischer, 2007).

The modal particle "*einfach*" is used in German to soften a request and to propose an "easy way" (Massud, 2002). This description is partially related to Pollet (2006) in that it is an evident thing to do or say. The main function of "einfach" is to describe a request as self-evident (Massud, 2002). Yet, it goes further that "*einfach*" can convey an "argumentative status with no room for negotiation" and with the function of closing down a topic (Massud, 2002). Apart from the non-negotiable nature of the modal particle, "*eifach*" is also described as a particle that links the current turn to a previously discussed topic. Aijmer (1996) argues that modal particles express epistemic modality. She develops this notion by stating that modal particles are able to encode the information necessary to update assumptions about expectations (Aijmer and Simon-Vandenbergen, 2004). By using particles (e.g. "*actually*" or "*of course*"), participants signal a "contrast with a previous claim" or indicate that it "strengthens what has been said" (Aijmer and Simon-Vandenbergen, 2004; p. 1784).

My findings indicate that "*eifach*" is used by patients as a way to demonstrate that the goal is linked to their own prior talk, thereby claiming a form of entitlement to the knowledge about goal. The following extract (Extract 5.7) is an example of the use of "*eifach*" to illustrate this argument.

The patient responds in a straightforward manner to the goal enquiry (see Extract 5.3 for the detailed analysis). After a first statement of a goal the patient continues with a post-expansion (Schegloff, 2007a), which provides additional information with regard to the stated goal. I argue that "*eifach*" links the first part of the response when the

patient proposes her goal (to be able to run again) with the post-expansion presenting the fact that she would like to do her sports again (line 15/17). The patient presents the goal in a way that can be considered "common sense" (self-evident) and therefore non-negotiable, asserting the patients' authority.

Extract 5.7: B04 PTd Rx1_6.58

13 Physio	E:::::hm (.) J:a und was isch dis Ziel?	
	U::::hm (.) Ye:s and what is your goal?	
14	(0.5) *((Physiotherapist looks at patient))*	
15 Patient	Mis Ziel isch dass ich wieder cha go jogge so wienich körperlich au ↑mag	
	My goal is that I again can go to jog like the way I physically also ↑be able	
	My goal is that I can go running again as much as I am physically able to	
16 Physio	**↑Mh[m]** *((Physiotherapist writes in chart))*	
17 Patient	[o]hni dass mi de Schmerz behinderet	
	[wi]thout that me the pain handicapped	
	without being bothered by the pain	
18	(2.1) *((Physiotherapist continues to write in her chart))*	
19 Patient	Eifacht dass ich die Sportarte wonich gern mache eifach wieder cha usfüehre=	
	MOD that I the types of sports that I like to do MOD again can execute=	
→	***Eifacht*[53] that I can *eifach*[54] do the sports again that I like to do and that I can**	
20	=und mi frei (.) cha füehle und-	
	=and myself free (.) can feel and-	
	feel myself ready and-	
21	(0.5)	
22 Patient	[Jo]	
	[Yes]	
23 Physio	**[Mhm.]** *((Physiotherapist looks at patient))*	
24	(1.1)	
25 Physio	Machsch no anderi Sportarte i dem Fall oder?	
	Do you do still other types of sport in that case huh?	
	In that case do you do other sports as well huh?	

In the first part of the response (line 15 and 17) the patient responds to the question in a straightforward manner (see Section 5.2.1). The therapist treats the goal as

[53] Approximate translation: "*simply*"
[54] Approximate translation: "*just*"

apposite by writing it in the chart (line 16 and 18). Even though the turn in line 17 could have ended the sequence the patient continues after a pause: "eifacht *that I can* eifacht *do the sports I like to do and that I can (.) feel myself ready and-*" (line 19). I argue that the use of the modal particle "*eifacht*" in the beginning of the turn suggests that the patient's expansion reinforces the source-based authority by giving a rationale why this goal is important for her. The patient's response is taken up by the therapist as she further investigates the type of sport activities the patient undertakes (line 24), thereby accepting the goal. This post-expansion of the response to the goal enquiry shows how the patient orients to having access to knowledge required in order to formulate a goal.

While in Extract 5.7 access to knowledge has been at the center of orientation, the next case illustrates how the tension between authority and subordination is played out all along. It therefore illustrates how asymmetry is not a fixed variable, but is constructed during the interaction. The patient employs "*eifach*" already in his initial response, but then modulates the previously stated goal after the therapist's restating the goal (line 24).

Extract 5.8: B09 PTe Rx1_20.06

11 Physio	.h Üches Ziel? (.) Herr X	
	.h Your goal? (.) Mister X	
12	(0.4) *((Physiotherapist shuffles paper and looks up))*	
13 Physio	do ide [Therapie]	
	here in the [therapy]	
14 Patient	[Jo eifacht] (.) ganz schmerzfrei werde oder (.) [ganz klar] oder	
	[PART MOD] (.) totally pain free to become huh (.) [totally clear] huh	
→	***Jo eifacht*[55] to become completely pain free huh (.) that's clear isn't it**	
15 Physio		[Schmerzfrei] werde
		[Painfree] to become
		To become pain free

Some lines omitted

[55] Approximate translation: "*well just*"

24 Physio	.hh Aber no schmerzfrei wärde (.) das heisst dass das Steche weg goht?	
	.hh But still pain free to become (.) that means that the stabbing away goes?	
	.hh But still to become pain free that means that the stabbing pain disappears?	
25 Patient	Jo	
	Yes	
26 Physio	So das no	
	So that still	
	That's that	
27 Patient	Dass eifacht (.) de ganz Bewegigsapparat- dass i de wieder- au wenni d'Chraft wirde=	
	That MOD (.) the whole movement machine- that I then again- even if I the force will=	
➡	**That *eifacht*[56] (.) the whole musculoskeletal system- that I can again- even if I lose the force**	
28	=verlüre (.) dass i de eifacht bhaute das isch [wichtig]	
	=lose (.) that I then MOD keep that is [important]	
➡	**that I *eifach*[57]*t* keep it this is important**	
29 Physio		[Guet (.) ↑mhm]
		[Good (.) ↑mhm] *((Physiotherapist starts to write))*
30 Patient	Das isch würklich s'Ziel od[er]	
	That is really the goal h[uh]	
31 Physio	**[M]hm.**	
32	(3.6) *((Physiotherapist writes in chart))*	

The use of "*eifacht*" in this example gives us an insight into the negotiation of epistemic stance. The patient's initial response "Jo eifacht *(.) to become completely pain free doesn't it (.) that's clear isn't it*" (line 14) indicates that his goal is self-evident. He also emphasizes his claim with "*that's clear*" followed by a tag question ("*isn't it*") which shows delicacy of the interactional work. The patient is able to preserve the asymmetry and attend to professional's authority while responding to the terms of the question (goal enquiry) and also reporting on a goal.

Starting in line 24, the physiotherapist comes back to the topic of pain by investigating if pain free means the pain in the shoulder. After a positive response to this question ("*Yes*" – line 25) the therapist closes down the turn with a "sequence-closing

[56] Approximate translation: "*simply*"
[57] Approximate translation: "*just*"

third" (Schegloff, 2007a). Her turn indicates the end of the sequence, but the patient 'expands' the goal discussion. In line 27 he starts the turn in a similar way, as shown in the straightforward responses but including "*eifacht*" changing thereby the tilt of the statement ("*that* eifacht *(.) the whole musculoskeletal system- that I can again – even if I lose the force (.) that I* eifacht *keep it*"). It seems that the formulation "*keeping it*" refers to the patient keeping the mobility of his shoulder while he might lose some of the strength in the arm. The post-expansion - as in the previous extract - is introduced by "*eifach*" and indicates that the goal is set to be accepted by the physiotherapist. The patient's statements "*this is important*" (line 28) and "*That is really the goal,*" (line 30) emphasise the patient's authority over the matter. There is a tension for the patient in treating the goal as self evident and something to which they have both access and entitlement, while at the same time treating himself as possibly not entitled to this level of certainty. I argue that the use of "*eifacht*" – as shown in this example – makes it difficult for the physiotherapist to disagree.

So far, I have shown that in some cases (Extract 5.7, 5.8) "*eifach*" is used in responses to propose unproblematic mutual access to the knowledge and the goal, as well as add authority to the claim about goals. By the use of the modal particle, patients ensure that they treat themselves as entitled to state a goal, and that therapists treat the presented goal as apposite. It is a constant struggle between asserting goals as part of the patients' domain while at the same time treating the therapist as authoritative with regard to professional knowledge about goals. The patients also manage in a subtle way the tug-of-war between cooperating with answering a question while at the same time conveying some asymmetry in knowledge with regards to the goal. In addition, it is also important for participants to find a balance between the types of knowledge (knowledge of their own body possessed by patient vs. expert knowledge owned by physiotherapist in regard to anatomy, physiology and pathology and also the possibilities of therapy, what it can achieve).

5.2.4 Evidential marker "*I think*"

In previous sections, I have shown that goals are proposed with different degrees of certainty, and that patients claim access and thereby entitlement by the use of the modal particle "*eifach*". In this section, I demonstrate how patients utilise the evidential marker "*I think*" to manage authority and how they show in their responses that they are aware of the therapist's authority over physiotherapy knowledge (e.g. prognosis). As I have shown in previous sections (4.2.3 and 5.2.2) on the one hand patients have knowledge with regards to their own body and experience, and might or might not know how physiotherapy can help them, and on the other hand therapists possess knowledge with regard to bodies in general, as well as what physiotherapy can do.

The following Extract 5.9 provides an example where "*I think*" is used as a resource to adjust expectations and to soften the entitlement to "own a goal". The patient, accompanied by her husband, comes to physiotherapy after surgery due to a fracture in her lower leg. She responds to the goal enquiry starting with "*I would like*", repairing it to "*I think if I could*". I argue that this repair changes the goal from a 'wish' (stronger entitlement with possibility not to achieve) to a more realistic goal (to be able to bend the knee again). This change incurs from a statement framed as a desire for something that is framed as a capacity.

Extract 5.9: G05 PTk Rx1_13.36

10 Physio	De hani no en (.) letzte ↑Frag was- was erwarte (.) sie (.) vu de Physiothera↑pie	
	Then have I still a (.) last ↑question what- what expect (.) you (.) from the physiother↑apy	
	Then I have just one last question what- what do you expect from physiotherapy?	
11	°was erwarte sie vu ↑mir	
	°what expect you from ↑me°	
	what do you expect from me?	
12 Patient	°Ehm °	
	°Uhm ° (*(patient looks away and down to her foot))*	
13	(2.4)	

14 Patient Jo i wetti gern- aso i denke weni s'chneu denn würklich wieder chan mache das isch scho viel

PART I would like- PART I think if I the knee then really again can make that is already a lot

***Jo*[58] I would like- *also*[59] I think if I could bend the knee again that would already be a lot**

15 (1.3) *((Physiotherapist continues to look at patient who looks at chart))*

16 Physio S'chnü mache ↑mhm

The knee make ↑mhm

To bend the knee mhm *((Physiotherapist turns to chart to write, but stops as patients laughs))*

17 Patient Und an und für sich wett ich scho hehe dass d(h)e- dass d(h)e (.)

And to and for it want I yet hehe that th(h)e- that th(h)e- (.)

And I would like as well hehe that th(h)e- that th(h)e-

18 s'ganze wieder guet chunnt [aber eh-]

the whole again good comes [but eh-]

the whole thing gets better again but eh-

19 Physio **[↑Mhm] ↑mhm**

20 Patient Jo.

Yes.

21 (1.0)

22 Physio Eifacht dass sie- [Hobbies- Hobbies- und so wieter eifacht wieder chöi mache]

MOD that you [hobbies- hobbies- et cetera MOD again could do]

***Eifacht*[60] that you can *eifacht*[61] do the hobbies- hobbies- etcetera again**

23 Husband [(Eifacht d'Beweglichkeit)]

[(*Eifacht*[62] the mobility)]

24 Patient [D'Beweglichkeit Aso dass ich das wieder cha mache] (.)

[The mobility So that I that again can do] (.)

The mobility So that I can do that again

25 Patient jo das wetti scho gern

yes this would I like to

yes I would like to

26 Physio **Mhm. (.) mhm.**

27 (8.3) *((Physiotherapist writes in chart))*

[58] Approximate translation: "*yeah*" or "*well*"
[59] Approximate translation: "*well*" or "*thus*"
[60] Approximate translation: "*just*"
[61] Approximate translation: "*simply*"
[62] Approximate translation: "*simply*"

28 Physio Okay (.) also (.) luegemer mol einisch? h.h.h (1.0) Guet
Okay (.) so (.) look we PART once? h.h.h (1.0) Good
Okay (.) so let's have *mol*[63] a look? h.h.h (1.0) Good

This example shows the use of "*I think*", but also the multiple use of "*eifacht*", by all participants (patient, her husband, and physiotherapist) and how, at the end of the sequence, a goal is proposed by the patient using a formulation similar to a previous example (line 22 - "*that I can do that again*").

This goal setting episode (Extract 5.9) starts with the physiotherapist enquiring about the patient's expectations (line 10 "*what do you expect from physiotherapy?*"), but he then adds a second question with reduced volume "*what do you expect from me?*" (line 11). The second question is delicate as it shifts the focus from a general view about physiotherapy to a personal appreciation. It is also a good example to show how assumptions are carried in the therapist's question. This question design does not pay attention to the fact that the patient might have trouble telling the therapist what he should do (expectations not only about physiotherapy, but about the physiotherapist). The patient's response to the goal enquiry starts hesitantly and after a long pause of 2.4 seconds ("jo *I would like*-" – line 14). She cuts off the turn and repairs it by replacing "*I would like*" with "*I think if I could bend the knee again that would be already a lot*". It is not always possible to conclude why a speaker repairs the turn (Sidnell, 2010) but repairs do influence the progressivity of the action. While the "*I would like*" takes into consideration a wish/desire, "*bending the knee*" makes reference to the body and is framed as "not having the capacity to do". The nature of physiotherapy is to work on movement capacities. The physiotherapist's repeat in line 16 "*to bend the knee*" acknowledges verbally and in an embodied way the reception (and acceptance) of the goal. During the therapist's writing, the patient retakes the floor by restating what she would like. This turn resembles the initial turn in line 14. The only difference is that the response is prefaced with *–and* which indicates a continuation to her previous

[63] Approximate translation: "*once*" but could also be in the sense of"*let's have a go*"

statement ("*And I would like as well hehe that th(h)e- that th(h)e- (.) the whole thing gets better again [but eh-]*"). It is also important to note that this turn is oriented to the possibility that this might be an unreasonable wish (laughter, "*but"* – line 17 and 18).

The physiotherapist overlaps at a possible turn completion ("*Mhm*" - line 19) and after a one-second silence he proposes a goal by linking "*eifacht*" to the previous talk about hobbies (yoga, walking): "*Eifacht that you can do the hobbies- hobbies- etcetera eifacht again*" (line 22). Even the husband who has been mainly quietly sitting apart collaborates in the construction of goal by uttering "*Eifacht the mobility*". The goal proposal is confirmed by the patient by using a "*that I can do that again*" (line 24) resembling the straightforward format discussed in Section 5.2.1. The final utterance by the patient "*yes I would like to*" (line 25) brings back the vocabulary of her initial response to the goal enquiry (line 14). The physiotherapist closes down the sequence and moves on to the next activity (line 28). This extract illustrates the patient's guessing work of what a 'correct goal statement' should look like. This uncertainty is expressed first by a *well*-prefaced response (see Section 5.2.2) and by the repair using the evidential marker "*I think*". In addition to that, the patient scales down from a wish/desire to a specific physical goal, which is then confirmed by the therapist ("*to bend the knee*" - line 16). It also supports the claim about "*eifach*" indicating that the modal particle attributes authority to the patient and claims mutual access (in this case attributed by the husband and the therapist).

The following extract 5.10 exemplifies that "*I think*" can be used to downgrade the entitlement to state goals and similarly to the previous extract to project an adjustment of a wish uttered by the patient. The patient is seeing the therapist for treatment of his hip arthritis. It is not his first time with this therapist but due to his young age a hip arthroplasty surgery has not been considered yet and the only option for pain relief offered to him is physiotherapy treatment.

Extract 5.10: B19 PTb Rx1 5.56

1 Physio	Was wär s'Ziel de jetzt vudere (.) Therapie[phase no einisch]	
	What would be the goal then now of this (.) therapy [phase once again]	
	What would be the goal for now for this therapy phase this time	
2 Patient		[He jo ↑stabili]siere (.)
		[He PART to ↑stabili]se (.)
		He *jo*[64] to stabilise
3	m[eh git]- meh liet jo nümm din[ne]	
	m[ore is-] more lies PART not any more in [it]	
	more there is- there is *jo*[65] not much more possible	
4 Physio	[Ja]	[↑Mh]m
	[Yes]	**[↑Mh]m**
5	**(2.9)**	
6 Patient	Aso i denke meh liet nümme dinne	
	PART I think more lies not any more in it	
	***Also*[66] I think there is not much more possible**	
7	(0.4)	
8 Physio	Ja	
	Yes	

The patient states his goal in an entitled way to state a fact (line 2 – 3, "*He* jo *to ↑stabilise (.) more there is- there is not much more possible")* which is not immediately ratified by the therapist. After a pause of 2.9 seconds (line 5) the patient adds an account that is repeated and downgraded with "*I think*" (line 6 – "aso *I think there is not much more possible*"). With this *well*-prefaced response the patient seems to be treating the turn as problematic and downgrades his claim using "*I think*". The initial expectation uttered by the patient is downgraded to a 'softer' version, going in line with the previous argument about the quest for balance between the patient's and the professional's domain, yet still orienting to the patient's entitlement to knowledge with regards to expectations about outcomes. As the patient has already received physiotherapy before with limited success, he can therefore rely on his own experience to which he has

[64] Approximate translation: "*well*"
[65] Approximate translation: "*still*"
[66] Approximate translation: "*well*"

primary epistemic access. This example also highlights the facts that if a patient's knowledge claim is not confirmed in an overt way (vocally or in an embodied way) by the therapist, the patient may orient to needing to downgrade.

5.2.5 Claim of no knowledge

The Sections 5.2.1 to 5.2.4 illustrate patients' responses to goal enquiry and their epistemic stance on a continuum from being certain about the goal (straightforward responses) to different degree of certainty and downgrading their knowledge (*well*-prefacing, tags). There is also a category, although just one case in my data, which brings us to the other end of the continuum: the no knowledge claim. I previously presented the link between straightforward responses and epistemic congruence. In this example, epistemic incongruence exists when the responder, i.e. the patient, claims not to have the knowledge necessary to answer the question (Heinemann, Lindström and Steensig, 2011). These claims of "no knowledge" may be problematic for the interaction (Keevaliik, 2011) as I show in the next examples. The patient's response is disaligned (Stivers and Hayashi, 2010) in that it resists the question's presupposition that the patient has a goal, and that he is able to report on it.

The patient (Extract 5.11) is referred to physiotherapy by his general practitioner and is on medical leave after having hurt his back during work (as a maintenance worker). The contingencies inherent to this interaction are therefore different compared to other examples as the patient did not choose to come for physiotherapy but has an obligation to do so. As there is only one case, unfortunately, the observation that this obligation may influence the patient's response here must remain a preliminary or tentative observation.

Extract 5.11: B16 PTe Rx1 16.35

8 Physio	Okay (.) .hh Was isch üches Ziel do vu de Therapie	
	Okay (.) .hh What is your goal here of the therapy	
	Okay (.) .hh What is your goal here for therapy	
9	(1.7)	
10 Patient	°Kei Ahnig he[hehe°]	
	°No idea he[hehe°]	
11 Physio	[hehehe] Werum siet ihr do was söll andersch werde [dhh]	
	[hehehe] Why are you here what should different become [dhh]	
	hehehe Why are you here what should be different	
12 Patient		[°Wi]eder (laufe) denki°
		[°Ag]ain (walking) think I°
		To walk again I think
13	(0.2)	
14 Physio	**↑Mhm**	
15	(3.5) *((Physiotherapist writes in chart))*	

The patient responds to the physiotherapist's enquiry after a 1.7 silence with "*no idea*" (line 10). This answer is uttered softly and is accompanied by laughter indicating interactional trouble (Haakana, 2002). One way to deal with disalignment and trouble in interactions is laughter, implying that his response is not to be taken seriously. The physiotherapist joins in the laughter and launches a follow-up question by formulating a question using different vocabulary: "*Why are you here what should be different*" (line 11). Through this move the therapist treats the activity of goal setting as needing completion and through this different formulation the therapist is able to elicit a response from the patient. The patient's response is uttered softly and formulated in the straightforward manner seen in Section 5.2.1 ("*to walk again*"). However, by using "*I think*" (line 12) he downgrades his claim to authority in this matter. Heinemann, Lindström and Steensig (2011) make a distinction in terms of responsibility of a non-answer: the 'fault' could be either in the questioner's or the question recipient's domain. In Extract 5.11, the patient at first treats the questioner's inquiry as questionable, but in the next turn complies with the question's constraint. The therapist treats the response as acceptable and writes it in her chart (line 15). This single case gives us insight into the

complexities of goal enquiry. Patients are expected to have a response, and they usually comply with this obligation. The constraints and contingencies of institutional interactions, however, are inherent to the activity of goal enquiry in physiotherapy.

In the findings section, I have shown, first, some straightforward responses, and second, how *well*-prefaces, tag questions, and evidential markers ("*I think*") help patients convey uncertainty with regard to the goal enquiry. By using the modal particle "e*ifach*" patients' authority in matters of goal setting is confirmed, yet sometimes only lightly demonstrated (e.g. when tags are used in conjunction with the modal particle). I argue that knowledge is not equally distributed and that if physiotherapists embed epistemic assumptions in their question, patients use resources such as those presented here to show potential incompatibility with assumptions embedded in the goal enquiry. While straightforward responses (Section 5.2.1) indicate epistemic congruence, various interactional devices indicate patients' uncertainty with regards to access to knowledge about goals as well as their entitlement (Section 5.2.2 - 5.2.4).

The balance between epistemic rights and responsibilities of participants is not easily achieved and requires a constant negotiation of epistemic stance. An epistemic see-saw (Heritage, 2012a) is observable in these patient-physiotherapist interactions. The goals are negotiated in a way that makes them achievable within the timeframe of allowed consultations.

Table 5.1 provides an overview of the aspects of goal enquiry elaborated on in this chapter. While straightforward answers are present in five interactions, there are different resources to be deployed to manage patients' epistemic stance. The degree of certainty about knowledge goes from very certain knowledge (K+) to no knowledge (K-) with different resources to downgrade knowledge claims (downgraded K) and assign responsibilities to either patients' domain (K in patient's domain) or participants' domain of knowledge (K in therapist's domain). The type of knowledge is indicated as either related to body knowledge (patients' experiences) or professional knowledge (general knowledge about bodies).

Table 5.1: Summary of patients' responses to goal enquiry

	Straight-forward responses	***Well*-prefaces Tag "*oder*"**	**Modal particle "*eifach"***	**Evidential marker "*I think*"**	**No knowledge**
Code	B04 B08 B10 B11 G02	B03 B06 B07 B09 B19 B20 G05	B03 B04 B09 B18* B20	B19 G05 B16	B16
Type of knowledge/ Entitlement	- Knowledge about own body/physical abilities - Knowledge about physiotherapy	- Knowledge about body/physical abilities	- Knowledge about body/physical abilities	- Knowledge about body/physical abilities - Reduced claim about specific physiotherapy knowledge	None
Degree of knowledge claim	K+	Downgraded K	Mutual access	K in participantsô domain	K-
Epistemic certainty	Certain ⟷ Uncertain				

* B18 is an exceptional case as there are two goal discussions. In the first session, the physiotherapist initiates the goal enquiry to which the patient responds with a delay. However, in the beginning of the second consultation, the patient comes back after having reflected on the topic and provides a response in a different way. However, this chapter includes only initial discussion and, therefore, the second consultation is not included.

5.3 Discussion

In this chapter I have discussed how patients respond to physiotherapists' enquiries about goals. In my analysis I described straightforward responses, and then examined less than straightforward responses, in these patients downgrade their epistemic rights using resources such as *well*-prefaces, tag questions, the modal particle "*eifach*" and evidential markers ("*I think*"). I showed how those practices treat knowledge as dynamic and how participants' epistemic stances are managed on a turn-by-turn basis. It becomes evident that enquiring about a goal is an activity which leads to participants negotiating authority over and entitlement to knowledge relating to therapy goals. The fine-grained analysis allows for an in-depth understanding of persisting asymmetries in the health care interactions I examined. Although there is a tendency today in healthcare to assume that asymmetry is problematic (see Section 2.2. on shared decision-making and patient-centred care), I have shown here that those asymmetries can serve important interactional functions. My findings contribute to the growing body of evidence about epistemics in interaction, but also offer a new contribution by extending the implications to a physiotherapy context and to the German language. I will now draw out the implications of these findings by considering how patients convey their epistemic stance during goal setting, reflecting on the type of knowledge that is at issue, and by discussing responses to *wh*-questions.

In my data, patients' responses to the therapists' enquiries about goals that use a question of the type "*what is your goal?*" or "*what do you expect from physiotherapy?*" are frequently less than straightforward. I was able to show that this type of goal enquiry embeds assumptions about access, entitlement, and rights and responsibilities of knowledge. When patients present goals without hesitations or hedging, the patients' response conveys epistemic assumptions congruent with those in the therapist's question, and the physiotherapists then treat those goals as apposite by acknowledging them either vocally or in an embodied way (i.e. by writing them down). If assumptions are not shared, interactional resources such as *well*-prefaces, tag questions, and evidential markers ("*I think*") are deployed to indicate the patient's epistemic stance and

to attend to the physiotherapists' professional status. Enfield (2011) differentiates between source-based authority (knowledge based on experience) and status-based authority (what you should know, are entitled to know). I argue that in a physiotherapy context, source-based authority is not sufficient, and it is subordinate to the status-based authority (see Section 5.2.2 on *well*-prefacing, tag questions; Section 5.2.4 on evidential marker "*I think*"). Patients sometimes treat the goal as not straightforward and as not part of their domain, even though they have knowledge about their bodies and their physical abilities. When assumptions with regard to access to and entitlement of knowledge between questioner (physiotherapist) and question recipient (patient) are compatible, epistemic congruence is achieved (Hayano, 2011; Heinemann, Lindström and Steensig, 2011).

Type of knowledge and asymmetry

I showed in the analytic section that the type of knowledge about goals influences the interaction between patients and physiotherapists and reinforces the asymmetry in the interaction. In straightforward responses patients claim knowledge about their bodies and physical difficulties (pain, trouble for certain activities). Knowledge about their own bodies is in the domain of patients (at least in terms of difficulties with certain physical activities or bodily sensations such as pain), but in the domain of physiotherapists (because of their professional and technical knowledge) in terms of prognostic assessments or treatment proposals.

In my data, the modal particle "*eifach*" is treated by participants as an indication of the type of evidence, based on the description of patients' experiences. This is in line with previous research on Swedish particles concluding that the type, strength and source of evidence for a claim can be expressed by modal elements (Aijmer, 1996). When patients convey their epistemic stance in relation to physiotherapy knowledge (e.g. prognosis, see Extract 5.9), they use the evidential marker "*I think*". Ariss (2009) points out that at times knowledge can be discussed in medical interactions with authority by patients with little actual knowledge or at other times a patient might possess knowledge without claiming authority with respect to that knowledge.

Therefore, claiming knowledge is different from 'knowing'. Yet, it has to be noted that the five cases of patients responding in a straightforward manner do have previous experience with physiotherapy and do have a certain level of physiotherapy knowledge (what physiotherapy can do or can not do). Nevertheless, previous experience with physiotherapy does not always produce straightforward responses, as many examples in this chapter indicate (Extracts 5.4., 5.5., 5.10).

Responses to wh-questions

The limited available research on responses to *wh*-question in everyday conversations documents that speakers hold each other accountable to respond to questions and suggests that certain structural features of responses are associated with problematic or non-problematic responses (Fox and Thompson, 2010; Schegloff and Lerner, 2009). Fox and Thompson (2010) analysed responses to *wh*-questions in non-institutional English interactions and concluded that clausal responses[67] have a different interactional function than phrasal responses. While my data does not support this claim, it does confirm that *jo*-prefaces and tag questions are practices to convey uncertainty about knowledge (Heritage, 2012a) and to fine-tune rights to knowledge (Hepburn and Potter, 2010). The "*well*" in turn-initial position of the second pair part (i.e. patient's response) alerts the physiotherapist about the non-straightforwardness of the patient's response. An unpublished paper on German interactions concludes that "*ja*" in turn-initial position following *wh*-questions serves a similar function (Barske and Betz, unpublished). This is also the case in my data.

I have shown in this chapter how patients respond to physiotherapists' enquiries about goals. Through analysing my data, I have demonstrated that knowledge is conveyed using various resources in such a way that participants orient to a delicate balance of what they know, what they are supposed to know and what they are entitled to know. The distribution of knowledge is managed and negotiated during the

[67] A *clause* includes a subject (e.g. a pronoun), followed by a verb and other items linked to the verb, such as an object, a prepositional phrase, or an adverb (Thompson and Couper-Kuhlen, 2005, p. 484). It can be independent (= stand-alone) or dependent. The *phrase* is a collection of words that may have nouns or verbs, but does not have a subject.

interaction by juggling between status-based and source-based authority. While patients have knowledge about their bodies (source-based authority) and might have had prior exposure to physiotherapy and understand what physiotherapy can do, physiotherapists possess professional knowledge (status-based authority) in general terms. I have shown in this chapter that patients convey their epistemic stance and sometimes attribute authority to the physiotherapist. Straightforward responses to *wh*-questions happen when epistemic assumptions are shared within participants' turn at talk. The next chapter sheds light on the trajectory of goal setting subsequent to patients' initial responses to the goal enquiry and examines how patients' initial responses sometimes are transformed in order to make them acceptable for physiotherapy.

Chapter 6 - "*So to do your housework faster*"
Follow-up and transformation of responses

6.1. Introduction

In the two previous chapters, I have shown how physiotherapists enquire about goals and how patients respond to this enquiry. I have described and analysed practices in which assumptions are embedded in questions and how patients convey their epistemic stance towards therapeutic goals and goal setting through various linguistic resources.

In this chapter, I analyse what follows patients' responses to therapists' goal enquiries. I noticed that some responses from patients lead to further discussions while others do not. I present in this chapter four different practices used by therapists after patients' initial response: a) **Response tokens** (4/14 cases), b) **Repetitions** or **partial repeats** (7/14 cases), c) **(Re-) Formulation**[68] of goals (7/14); and d) **Transformation** of goals (4/14). I demonstrate that when therapists primarily use response tokens (mostly "*mhm*"), the activity of goal setting is confined to documenting a goal, and patients do not elaborate further on the topic. In contrast to the weak response token "*mhm*", repeats are sometimes oriented to by patients as an invitation to elaborate on the topic. I argue that response token and repetitions function mainly as an acknowledgment of receipt of a response.

Formulations, quite common in my data, are used as devices to close down the goal discussion and to move on to the next topic. Through the use of formulations, therapists achieve two things: they show patients that they have been listening to their talk by linking goals to problems presented earlier, and they reshape goals into a format that is useful for their professional practice, namely to have function-oriented goals.

[68] I decided to use the term "formulation" for both instances in which therapists reformulate a goal previously formulated by the patient, and when therapists draw on prior talk to suggest a goal. This is in line with Hutchby's (2007) argument that while some articles talk about reformulations, formulation is still the most common term in the literature for this type of practice.

The final practice presented in this chapter involves therapists transforming patients' initially stated goals. The longest goal discussions in my data are the four cases in which goals are transformed through talk, meaning that the endpoint of the discussion is qualitatively different than the initial suggestions given by the patient. This transformative process shows that goals are not just entities in patients' heads that can be pulled out when they are asked for, but that there are different levels of collaboration or interaction that makes those jointly negotiated goals acceptable for physiotherapy practice.

Before presenting the findings, I review relevant CA studies about acknowledgement/response tokens, about how formulations are used in different contexts, and about practices through which responses are transformed.

6.1.1. Response tokens

Mm and *Mm hm* are tokens listeners can use to show that they are attentive to the speaker. Various names describing this practice are used in the literature, from acknowledgment tokens (Drummond and Hopper, 1993) to backchanneling (Yngve, 1970). Fujimoto (2007) stresses the importance of differentiating between various functions and argues that the terms 'backchannel' or 'feedback' are too general in their summary of listener responses. Gardner (2001) shows how different response tokens such as *mm* or *mhm*, can have various intonational contours: a falling intonation is described as acknowledgment of a problem-free receipt of the prior utterance, a fall-rising intonation is an index of need for further talk from the other, while a rise-falling intonation seems to indicate a problem-free receipt, but with an overlay of heightened involvement in the talk (Gardner, 1997). Gardner describes four main functions of response tokens: a) continuers (such as *mhm*), which hand the floor immediately back to the speaker; b) acknowledgments (such as *mm* and *yeah*), which claim agreement or comprehension of the prior turn; c) newsmakers (such as *oh* and *right*), which mark the prior turn as newsworthy; or d) change-of-activity tokens (such as *okay* and *alright*), which indicate the introduction of a new topic or action in a conversation (Gardner,

2001). The function of *mhm* in my data is of two kinds: a continuer (rising intonation) and acknowledgment token (falling intonation).

Acknowledgment tokens *Mm hm* and *Uh huh* have been investigated by Drummond and Hopper (1993). They analysed phone calls both between family members, friends as well as in a healthcare context (cancer information centre) and were interested in finding out whether those tokens were distinguishable as freestanding response token or as tokens that induces speakership. Their findings indicate that there were differences between family and friends' conversations, and institutional interactions. The talk in a cancer information centre shows the highest use of those acknowledgment tokens. The authors found 36 instances of *Mm hm*, and 11 instances of *Uh huh* in the institutional interaction, compared to mother-daughter talk or discussions between friends.

In summary, a response token can either immediately hand the floor back to the speaker or it can be used as an acknowledgement token to signal receipt, but in either case "acknowledgment tokens are interactional achievements" that are improvised on a turn-by-turn basis (Drummond and Hopper, 1993, p. 176).

6.1.2. Repetitions

Similar to response tokens "*mhm*", repetitions in talk are quite common. A repeat is when something is heard "twice in succession" (Jefferson, 1972; p. 269). First of all, repetitions can be differentiated according to sequential environments: same-speaker repetition or other-speaker repetitions achieving different sorts of actions (Wong, 2000). In this chapter, I focus on other-speaker repetitions. Jefferson (1972) differentiates between different functions: surprise repeat (questioning repeat to signal that there is a problem and to remedy it), enjoyment (laugh tokens repeat to terminate the talk), affirmation repeat (to continue talk) and request for information. Svennevig (2003) describes echo-answers in which a response repeats elements of the question. He further argues that when a speaker indicates receipt of information by repeating the utterance of the prior speaker it does not mean that s/he commits to the truth of the

statement, but only that the statement has been registered (Svennevig, 2004). In addition to the function of information receipt, this type of repetition serves also as "sequence- and topic-closing move" (p. 490), and a speaker indicates that s/he heard and understood the prior speaker's utterance (Svennevig, 2004). Another strand of investigation into repeats has looked at repeats of questions and their interactional function (Bolden, 2009a; Robinson and Kevoe-Feldmann, 2010), however, this is not directly relevant to my analysis as it concerns the second turn (response to question) and not the third turn (repeat of response). The information receipt function described by Svennevig (2004) is the focus of this chapter, and I present examples in which the therapist uses repetition to indicate having heard the patient's response.

Repetitions by another speaker can initiate repair, register receipt, signal correction/disagreement (Wong, 2000) or agreement (and allude to prior talk) (Schegloff, 1996). The difference between repetition and formulation is that repetition indicates hearing, whereas formulation displays understanding (Svennevig, 2003), which I will present in the next section.

6.1.3. Formulations and transformations

In this section I first explore the term formulation, its linguistic structure and function, before describing what I understand by transformation. Formulations in the CA literature are analysed in different settings, from doctor-patient interactions to psychotherapeutic practice. Heritage (1985) defines formulations, mostly done by questioners, as "summarizing, glossing, or developing the gist of an informant's earlier statements" (p. 100). Formulations are candidate re-presentations of what an interlocutor is understood to have said, or meant (Hutchby, 2007, p. 83). While 'reformulation' might be a more adequate term, the literature commonly uses the term 'formulation' and so I also use this term throughout this thesis.

In terms of linguistic structure, formulations in English are often prefaced with '*so',* and participants use those prefaced upshots to link different elements of the talk (Raymond, 2004). The 'so'-prefaced upshots "are one practice for indexing or

highlighting the connection between a current turn and a more encompassing unit of organization in which it participates" (Raymond, 2004; p. 189). Along the same line, Bolden (2009b) demonstrates that 'so' is deployed to mark an upcoming topic that is still pending. With regards to the German language, in institutional interactions, Deppermann (2011) shows that the German "*also"* corresponds to the English "*so*" and is the most common item to index a formulation which is framed as having been meant implicitly by the prior speaker in his/her previous turn (i.e. a gist formulation). While *"also"* is a linguistic device for prefacing formulations in German, it has other functions as well, such as indexing self-repair (Deppermann, 2011), which are less relevant for this chapter.

Formulations project agreement (Heritage and Watson, 1980), and they are designed to link back to previous discussions while, at the same time, to move forward from them (Barnes, 2007). Two kinds of formulations are described in the literature: a 'gist formulation', which means deleting, selecting and rephrasing what has been said, or an 'upshot formulation', which extracts an implication from the surface by deleting parts of the account and thereby transforming it to a certain degree (Heritage and Watson, 1980; Antaki et al, 2005). Antaki (2008) describes three functions of formulations in institutional talk: 1) to interpret the patient's talk, 2) to close down a therapeutic interview, or 3) to "cast the client's symptoms in a more suitable way" (p. 34). Furthermore, formulations can be used as a device of active listening because they do more than just receive information (Hutchby, 2005). Formulations do not only function as markers to highlight specific aspects of the prior turn, but also as ways to "potentially assist in topicalising therapeutic matters" (Hutchby, 2007, p. 89).

Not much has been written about transformations in the way I use the term in this chapter. Transformation has been employed by some CA researchers (Stivers and Hayashi, 2010), but their analysis focuses on transformation of the questions and describes, therefore, a different phenomenon. Another way to approach transformation is to talk about 'categorical transformation' (Hester and Hester, 2012). Instead of just

define categories with respect to persons, they suggest that "conversational objects" (non-personal objects) can also be categorised. The authors argue that "persons are able to distinguish one type of conversational object from another" (Hester and Hester, 2012, p. 567). For the purpose of this chapter, I use the term 'transformation' in this sense and show how goals (conversational object) get transformed into a qualitatively different goal. While formulations function as a way to draw on prior talk, transformations go a step further and arrive at an endpoint that is different from where the goal description started. By different endpoint I mean that the goal does not resemble the initial response uttered by the patient (proposed goal stated by patient "*not to feel dizzy*" and suggested goal "*to do your household faster*").

6.2. Findings

In this Chapter I analyse what happens after patients' initial responses to goal enquiries. In the first part, I present examples in which therapists use response tokens to respond to the goals presented by patients (4/14 cases). Those tokens, mainly "*mhm*", are deployed by the therapists in combination with writing. In these four cases, the physiotherapists do not pursue the response further and treat the goal activity as complete. The activity is concluded with the therapist documenting in the chart. In 7/14 cases therapists use partial or modified repeats. Neither response tokens nor repeats rely on prior talk other than the immediate prior turns. This is in contrast to the two other practices – formulation (7/14) and transformation (4/14) - which rely on the knowledge of prior discussions. Through the use of formulations, therapists demonstrate that they listened to patients' presentations and draw on prior exchanged information in order to focus on relevant elements of response. The practice of transformation documents how therapists work on the initial goal statement to propose a qualitatively different, therapeutically acceptable goal. The final section of the chapter discusses those findings.

6.2.1. Response tokens and repetitions

The first extract (6.1) gives an example of the therapist's use of response tokens ("*mhm"*). When the therapist uses a rising intonation "↑*mhm*", the patient treats that

response token as a continuer, whereas the patient orients to the therapist's "*mhm*" with falling intonation as a signal that the goal setting activity as completed. The patient has been referred to physiotherapy for a knee problem that limits all her sports activities. The extract starts directly with the goal sequence (for entire goal episode see Appendix G).

Extract 6.1: B04 PTd Rx1_6.58

13 Physio	E:::::hm (.) J:a und was isch dis Ziel?
	U::::hm (.) Ye:s and what is your goal?
14	(0.5) ***((****Physiotherapist looks at patient))*
15 Patient	Mis Ziel isch dass ich wieder cha go jogge so wienich körperlich au ↑mag
	My goal is that I again can go to jog like the way I physically also ↑be able
	My goal is that I can go running again as much as I am physically able to
16 Physio	**↑Mh[m]** ***((****Physiotherapist writes in chart))*
17 Patient	[o]hni dass mi de Schmerz behinderet
	[wi]thout that me the pain handicapped
	without being bothered by the pain
18	(2.1) *((Physiotherapist continues to write in her chart))*
19 Patient	Eifacht dass ich die Sportarte wonich gern mache eifach wieder cha usfüehre=
	MOD that I the types of sports that I like to do MOD again can execute=
	Eifacht[69] **that I can *eifach***[70] **do the sports again that I like to do and that I can**
20	=und mi frei (.) cha füehle und-
	=and myself free (.) can feel and-
	feel myself ready and-
21	(0.5)
22 Patient	[Jo]
	[Yes]
23 Physio	**[Mhm.]** *((Physiotherapist looks at patient))*
24	(1.1)
25 Physio	Machsch no anderi Sportarte i dem Fall oder?
	Do you do still other types of sport in that case huh?
	In that case do you do other sports as well huh?

The patient's initial response (line 15) is acknowledged by the therapist (line 16) with a rising intonation inviting the patient to continue, which the patient accepts by

[69] Approximate translation: "*simply*"
[70] Approximate translation: "*just*"

adding an expansion about the pain (line 17 – "*without being bothered by the pain*"). Following this statement, the therapist withholds a comment while writing, and the silence is broken by the patient adding *"*Eifach *that I can* eifach *do the sports I like to do and that I can (.) feel myself ready and- "* (line 19). This information is only minimally acknowledged by the therapist (line 22 – "*Mhm*."), but this time with a falling intonation indicating a "problem-free receipt" of the prior utterance (Gardner, 1997; p.132). By moving to the next topic the therapist treats the patient's response as complete and does not further pursue the answer. With this extract I show that the same token can have two different functions, either being used as a continuer (line 16) or as an acknowledgment token to close down the topic and move on. Gardner (1997) observes that after an acknowledgment token with a falling terminal pitch direction (as in line 23), the talk usually does not continue on the same topic, which is also the case here.

Extract 6.2 shows a second example in which the therapist uses "*mhm*" to acknowledge the patient's response. It confirms the two different functions of "*mhm*" presented in the previous extract, but also includes two other resources, repetitions and formulations. I address the first topic now, while I develop the latter later in Section 6.2.2.

The patient was referred to therapy after a fracture of the lower leg. She has a cast and is not allowed to put weight on this leg for 6 weeks.

Extract 6.2: G05 PTk Rx1_13.36

10 Physio	De hani no en (.) letzte ↑Frag was- was erwarte (.) sie (.) vu de Physiothera↑pie	
	Then have I still a (.) last ↑ques□on what- what expect (.) you (.) from the physiother↑apy	
	Then I have just one last question what- what do you expect from physiotherapy?	
11	°was erwarte sie vu ↑mir	
	°what expect you from ↑me°	
	what do you expect from me?	
12 Patient	°Ehm °	
	°Uhm ° (*((patient looks away and down to her foot))*	
13	(2.4)	

14 Patient Jo i wetti gern- aso i denke weni s'chneu denn würklich wieder chan mache das isch scho viel

PART I would like- PART I think if I the knee then really again can make that is already a lot

***Jo*[71] I would like- *also*[72] I think if I could bend the knee again that would already be a lot**

15 (1.3) *((Physiotherapist continues to look at patient who looks at chart))*

16 Physio S'chnü mache ↑mhm

The knee make ↑mhm

To bend the knee mhm *((Physiotherapist turns to chart to write, but stops as patients laughs))*

17 Patient Und an und für sich wett ich scho hehe dass d(h)e- dass d(h)e (.)

And to and for it want I yet hehe that th(h)e- that th(h)e- (.)

And I would like as well hehe that th(h)e- that th(h)e-

18 s'ganze wieder guet chunnt [aber eh-]

the whole again good comes [but eh-]

the whole thing gets better again but eh-

19 Physio **[↑Mhm] ↑mhm**

20 Patient Jo.

Yes.

21 (1.0)

22 Physio Eifacht dass sie- [Hobbies- Hobbies- und so wieter eifacht wieder chöi mache]

MOD that you [hobbies- hobbies- et cetera MOD again could do]

***Eifacht*[73] that you can *eifacht*[74] do the hobbies- hobbies- etcetera again**

23 Husband [(Eifacht d'Beweglichkeit)]

[(*Eifacht*[75] the mobility)]

24 Patient [D'Beweglichkeit Aso dass ich das wieder cha mache] (.)

[The mobility So that I that again can do] (.)

The mobility So that I can do that again

25 Patient jo das wetti scho gern

yes this would I like to

yes I would like to

26 Physio **Mhm. (.) mhm.**

27 (8.3) *((Physiotherapist writes in chart))*

28 Physio Okay (.) also (.) luegemer mol einisch? h.h.h (1.0) Guet

Okay (.) so (.) look we PART once? h.h.h (1.0) Good

Okay (.) so let's have *mol*[76] a look? h.h.h (1.0) Good

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[71] Approximate translation: "*yeah*" or "*well*"
[72] Approximate translation: "*well*" or "*thus*"
[73] Approximate translation: "*just*"
[74] Approximate translation: "*simply*"
[75] Approximate translation: "*simply*"

The physiotherapist enquires about her goal for therapy (line 10) and the patient responds after hesitation. As discussed in Chapter 5 (Section 5.2.4), the patient indicates uncertainty about the goal (pause, *well*-prefacing, "*I think*"). The patient's response is ratified by the therapist using a partial repeat followed by a continuer ("*to bend the knee ↑mhm*" – line 16). Again, the patient treats "*mhm*" with rising intonation as a continuer and adds more information "*that the whole thing gets better again but-*" (line 18).

Even though the therapist uses response tokens as continuers (twice "*↑mhm*" – line 19) the patient does not provide further information, but treats her turn as complete (line 20 – "*yes*"). After a short pause the therapist continues to provide a formulation of goals ("Eifacht *that you can* eifacht *do the hobbies- hobbies- etcetera again"* – line 22) which is agreed upon by the patient and then closed down by the therapist at first with an acknowledgment token ("*mhm*" with falling intonation - line 26), the activity of writing (line 27), a topic closing "*okay*" (line 28) and a projection for the new activity (line 18 – "*let's have a look*") introducing the physical examination phase. The formulation used by the therapist in line 22 is just one additional example of what I describe in Section 6.3. The modal particle "*eifacht*" in the turn-beginning has a function similar to the one discussed in Section 5.2.3, namely that the goal can be linked to prior talk.

In Extract 6.3 the patient is referred to physiotherapy for a broken arm due to a fall at home. This sequence is from the second session and the therapist mobilises the shoulder joint passively when she asks the patient about her goals. It is therefore quite a different episode as the goal talk goes in parallel with a physiotherapeutic intervention.

Extract 6.3: B08 PTd Rx2_9.58

1 Physio	Dörfed	echli mithelfe
	Are allowed you a bit to help with	
	You are allowed to help a bit	
2	(2.0) *((Physiotherapist is mobilising patient's elbow))*	
3 Physio	°Genau°	
	°Exactly°	
4	(0.8)	

[76] Approximate translation: "*once*" but could also be in the sense of"*let's have a go*"

5 Physio Guet

Good

6 (3.6)

7 Physio .hh Und was isch Eues ↑Ziel

.hh And what is your ↑goal

8 (0.5)

9 Physio Was möchteder wieder mache nächher wenn das-

What would like you again do afterwards when this-

What would you like to be able to do again afterwards when this-

10 Patient Alles woni jetzt gmacht [↑ha]

Everything that I now done [↑have]

Everthing I did before

11 Physio [Aues] woder bisher gma[cht heid]

[Everything] that you before do[ne have]

Everything you did before

12 Patient [Aso go turne goni] nümm.

[So to do gymnastics go I] not anymore.

So I am not going to do gymnastics anymore.

13 (0.6)

14 Physio ↑Eh[e]

↑Uh[um]

15 Patient [Will] mir si amal nümme mengs (.) und denn isch es echli längwielig.

[Because] we are at times not anymore many (.) and then is it a bit boring.

Because we are not many anymore at times (.) and then it is a bit boring.

16 (0.4)

17 Physio **Ehe [mhm]**

18 Patient [Denn] chame nüme so .hh Spieli mache [und-]

[Then] can one not anymore so .hh games do [and-]

Then we cannot play games anymore and-

19 Physio [Grad] no wietermache [dezue näh]

[Just] still continue do [additional take]

Just continue add this one

20 Patient [denn] chame =

[then] can one =

then we cannot play

21 =nümme so Spieli mache und denn [isch's] längwielig

=not anymore such games do and then [it is] boring

any more games and then it is boring

22 Physio **[↑Mhm]**

23 (0.6)

24 Physio **Mhm**

Discussion follows about knitting

Extract 6.3 shows both features previously described: the response tokens and the repetitions uttered by the therapist. In line 11 the therapist repeats partially the patient's response in overlap ("*everything that you did before*"), only changing the pronoun from "*I*" to "*you*". This repeat is treated by the patient as a continuer, and the patient provides more information, specifying "*everything*" to "*not gymnastics*" (line 12). The therapist uses a continuer with open mouth ("*↑uhum*" – line 14), and the patient continues to elaborate on the topic and explains why she does not go to the gymnastic classes anymore (line 15 – *"because we are not many anymore at times and then it is a bit boring"*). The subsequent response tokens (line 17) are treated by the patient as continuers even though the intonation is neither rising nor falling. These response tokens could have been a possible pre-closing as the therapist comes in overlap with the patient's explanation and brings the focus back to the exercise she is doing with the patient (mobilising the elbow). It is evident here that goal talk is not the primary activity, but 'accompanies' the therapist's intervention.

In line 19 the therapist then gives the patient an instruction to continue ("*just continue add this one*"). The patient, however, comes in again in overlap to repeat her prior utterance (line 20 and 21 – "*then we cannot play any more games and then it is boring*"). In contrast to the therapist's repeat (line 11), the function of the patient's repeating her own utterance (self-repeat) is different. Because the therapist does not acknowledge the patient's statement (line 18) and concentrates at the action at hand, the patient orients to the turn as needing completion. She repeats the statement using the same formulation and completes the utterance. The therapist uses again a continuer (line 22) in overlap, before she utters a straight "*mhm*". This extract shows that the therapist acknowledges the patient's response to the goal enquiry by using repetitions to show that she registered the response.

In summary, in this section I have demonstrated that therapists show through the use of response tokens and repetitions that they have heard the patients' responses to their goal enquiries. The differentiation between "*mhm*" as a continuer (rising intonation) and "*mhm*" as an acknowledgment token described by Gardner (2001) on British and American English can also be confirmed, even though there are some instances where this differentiation is not so clear (straight "*mhm*" in Extract 6.3). Repetitions are often associated with "*mhm*", yet can be used as standalone utterances. Both repetitions and "*mhm*" with a rising intonation are commonly treated by patients as continuers. This can be observed when patients elaborate more about their goals.

Yet, as I have already indicated in Extract 6.3 therapists sometimes draw upon exchanged topics that have been discussed earlier in the consultation. It is therefore not surprising that formulations are used less frequently when goal enquiries are done in the beginning of the consultation. This will bring us to the next section in which I examine formulations in the context of goal setting as this practice relies on prior exchanges on related topics.

6.2.2. Formulations

In half of the cases, therapists use formulations as a response to the goal statement. I would like to reiterate that I use the term formulations to refer to instances in which therapists perform some operations (eg specify, recategorise) on the patient's initial goal suggestion/response (e.g. "*sports*" is replaced by "*running*"), as well as to draw on previously referenced information (e.g. "*things*" become "*hobbies*"). Yet, I do not include practices in which the endpoint is qualitatively different from the one in the beginning, which I call "transformation" and present in Section 6.2.3. (e.g. "*dizziness*" is transformed into "*doing household faster*"). Formulations function as devices for therapists to indicate to patients that they have heard and understood the problems patients face and to select certain aspects (especially functional limitations or problematic activities) from prior talk. Formulations can be used by therapists in addition to other resources such as response tokens and repetitions discussed in Section 6.2.1.

In Extract 6.4 the patient is seeking physiotherapy services after a shoulder injury. He had to undergo surgery and was discharged from the hospital the previous day. The sequence is divided into two parts. In the first part, we see how the therapist uses response tokens and repetitions, whereas in the second part, the formulation will be introduced. The discussion before the presented sequence concerns movements the surgeon had advised the patient to avoid (see Appendix G). The goal setting sequence starts in line 11.

Extract 6.4: B09 PTe Rx1_20.06 – Part 1

11 Physio	.h Üches Ziel? (.) Herr X
	.h Your goal? (.) Mister X
12	(0.4) *((Physiotherapist shuffles paper and looks up))*
13 Physio	do ide [Therapie]
	here in the [therapy]
14 Patient	[Jo eifacht] (.) ganz schmerzfrei werde oder (.) [ganz klar] oder
	[PART MOD] (.) totally pain free to become huh (.) [totally clear] huh
	***Jo eifacht*[77] to become completely pain free huh (.) that's clear isn't it**
15 Physio	[Schmerzfrei] werde
	[Painfree] to become
	To become pain free
16	**↑Mhm** *((Physiotherapist starts writing before mhm))*
17	(1.2) ((*Physiotherapist writes in chart*))
18 Patient	Ohni Medi ohni irgend- aso guet ich bi jo sowieso gege das ich nimme würklich=
	Without medication without any- PART good I am PART anyhow against that I take really=
	Without medication without any- *also*[78] alright I am *jo*[79] anyhow against that I only take
19	=nume s'Minimum [woni muess näh]
	=only the minimum [that I must take]
	the minimum I have to
20 Physio	[Woder müesst vu Medik]ament (.) guet (.) [ok(h)ay]
	[That you have to of medic]ation (.) good (.) [ok(h)ay]
	((Physio looks up)) **That you have to take the medication (.) good (.) o(h)kay**
21 Patient	[Das isch scho gnueg guet]
	[This is already enough good]
	This is already good enough

[77] Approximate translation: "*well just*"
[78] Approximate translation: "*well*"
[79] Approximate translation: "*anyway*"

22 (0.4)

23 Patient gnue

enough

24 Physio .hh Aber no schmerzfrei wärde (.) das heisst dass das Steche weg goht?

.hh But still pain free to become (.) that means that the stabbing away goes?

.hh But still to become pain free that means that the stabbing pain disappears?

25 Patient Jo

Yes

26 Physio So das no

So that still

That's that

27 Patient Dass eifacht (.) de ganz Bewegigsapparat- dass i de wieder- au wenni d'Chraft wirde=

That MOD (.) the whole movement machine- that I then again- even if I the force will=

That *eifacht*[80] (.) the whole musculoskeletal system- that I can again- even if I lose the force

28 =verlüre (.) dass i de eifacht bhaute das isch [wichtig]

=lose (.) that I then MOD keep that is [important]

that I *eifach*[81]*t* keep it this is important

29 Physio [Guet (.) ↑mhm]

[Good (.) ↑mhm] *((Physiotherapist starts to write))*

30 Patient Das isch würklich s'Ziel od[er]

That is really the goal h[uh]

31 Physio **[M]hm.**

32 (3.6) *((Physiotherapist writes in chart))*

In line 11, the therapist initiates the goal enquiry, and the patient responds with a *well*-prefaced goal in overlap ("Jo eifacht *to become completely pain free huh (.) that's clear huh"* – line 14). The therapist uses a modified repeat downgrading from the patient's utterance "*completely pain free*" to "*become pain free*" (line 15) followed by a continuer ("*↑mhm*" - line 16). As in the previous example, the patient treats this response token as a continuer and continues his talk by indicating that he does not want to use pain medication (line 18 – "*without medication without any- well I am anyhow against that I only take"*). The therapist responds with another modified repeat (line 20) and a pre-closing ("*good*" and "*okay*"), which the patient acknowledges as well. However, the therapist does not treat the goal setting activity as complete and pursues

[80] Approximate translation: "*simply*"

[81] Approximate translation: "*just*"

the topic with a modified repeat coming back to the topic of "*pain free*" (line 24 -*.hh But still become pain free)* followed by a clarification using "*which means*" ("*which means that the stabbing pain disappears?").* The patient confirms this suggestion and the therapist utters "*That's that*" (line 26), which could have been a closing turn, but the patient again adds more information. The final three lines of this extract illustrate the previously discussed difference between a "*mhm*" with rising intonation (treated as continuers) followed by the "*mhm*" with falling intonation (line 31). The patient does not treat the sequence as complete and continues with more talk. After a pause during which the therapist writes in her chart, the patient continues his talk.

Extract 6.5: B09 PTe Rx1_20.06 – Part 2

33 Patient	Dass nächher no chli öppis wird fähle isch jo ↑klar oder aber i wott eifacht [dass i-]	
	That afterwards still a little bit will miss is PART ↑clear huh but I want MOD [that I-]	
	That there will still be a bit missing afterwards that's *jo*[82] clear huh but I *eifacht*[83] would like that I-	
34 Physio		[Dass Ihr] wieder=
		[That you] again=
		That you could
35	= chönd funktioniere im Alltag he	
	= could function in every day huh	
	function again in day-to-day activities huh	
36 Patient	Jo	
	Yes	
37	(5.8) *((Physiotherapist writes in chart))*	
38 Physio	Guet (.) .hhh heit ihr no e Kontrolltermin bim Dr. D	
	Good (.) .hhh have you still a control appointment with Dr. D	
	Good (.) .hhh do you have a medical appointment with Dr. D	

In this second part of the episode, the patient adds more information downgrading his expectations about the results of therapy (line 33 – *"That there will still be a bit missing afterwards that's clear huh"*). The therapist comes in in overlap with a formulation in line 34 – 35 that is unrelated to the goal discussion shown in Extract 6.4

[82] Approximate translation: "*evidently*"
[83] Approximate translation: "*just*"

(lines 14 – 30). The formulation does not address the patient's concern about "*to become pain free*"; instead, the therapist picks up on functional activities, thereby proposing a different goal, which is subsequently accepted by the patient without delay. The tag question following the formulation (line 35 - "*that you could function again in day-to-day activities huh*") indicates a downgrading of the proposed goal, thereby illustrating how the therapist orients to the delicacy of the move. The proposed goal, which is easily agreed upon by the patient, is not based on his first response to the goal enquiry (line 14), but as this example shows the goal is interactionally achieved (jointly produced). While response tokens and repetitions function as listeners' devices, formulations are used to orient to the therapist's interpretation of the patient's status based on his/her professional knowledge. Through the use of formulations, therapists can create physiotherapy acceptable goals and thereby shape the patients' narratives into information useful for their practice.

In contrast with the previous example, the next case provides evidence that formulations are sometimes produced based on prior discussions. The next three extracts of the same case demonstrates how formulations are built upon earlier exchanges and how earlier matters get incorporated into formulations of goals. First, I show the beginning of the first consultation when the patient states her main problem (Extract 6.6 - hip pain which prevents her from running). Second, I present a summary sequence (Extract 6.7) which retakes the problem presentation and which might explain some of the features in the goal setting sequence a few minutes later. Finally, I present the goal setting sequence (Extract 6.8) that takes place towards the end of the first therapy session to demonstrate the features of this practice.

Extract 6.6: B07 PTd Rx1_1.05

1	Physio	Werum chömed ihr zu mir id Therapie?
		Why come you to me in the therapy?
		Why do you come to me for therapy?
2		(0.5)

3 Patient Auso agfange het das (.) jo i sege jetz mol vor öpp::e zwe Mönet

PART begun had it (.) PART I say now PART ago abou::t two months

***Auso*[84] it began (.) *jo*[85] I would say now *mol*[86] about two months ago**

4 (0.2)

5 Physio **↑Mhm**

6 Patient De hani eifach gmerkt nachem Jogge

Then have I MOD realised after the jogging

Then I have *eifacht*[87] realised after running

7 (0.2)

8 Physio **↑Mhm**

9 Patient und zwar

and indeed

in fact

10 (0.7)

11 Patient zerscht nach de grosse Läuf aso i sege jetz mol öppe so 11 Kilometer

at first after the big races PART I say now PART approximately 11 kilometers

at first after the long races *also*[88] I say now *mol*[89] after approximately 11 kilometers

12 Physio **↑Mhm**

13 Patient Das hani am andere Tag (.) nume no schlecht chönne laufe und i han immer geseit es sig d'Hüft aber

That have I on the other day (.) only still bad could walk and I have always said it were the hip but

Then the other day (.) I was only able to walk badly and I always said that it was the hip but

14 (.) nächer het de Doktor feschtgtellt es isch ned (.) d'Hüft vu un[ne (.)]=

(.) afterwards has the physician detected it is not (.) the hip from be[low (.)]=

afterwards the physician discovered that it was not the hip from underneath

15 Physio **[↑Mhm]**

16 Patient =aber obe hinderem Chnoche öp[pis]

=but up behind the bone somet[hing]

=but it was something on the upper part behind the bone

17 Physio **[↑Mhm]**

18 Patient ich ha dem gäng ned eso Beachtig gschenkt und ha denkt ich tue halt echli schone=

I have this always not so attention given and have thought I do PART a bit rest=

I have not given this much attention and I thought that I *halt*[90] rest a bit

---

[84] Approximate translation: "well"
[85] Approximate translation: "*well*"
[86] Approximate translation: "*just*"
[87] Approximate translation: "*just*"
[88] Approximate translation: "*I mean*"
[89] Approximate translation: "*about*"
[90] Approximate translation: "*simply*"

19		=susch walki halt de [.hh]
		=otherwise walk I PART then [.hh]
		otherwise I will then *halt*[91] do walking .hh
20	Physio	**[↑Mhm]**
21	Patient	aber das het eigentlich au ned meh ↑brocht
		but this has actually also not much ↑brought
		but this actually did not help much either
22	Physio	Ja
		Yes
23		**(0.2)**

The therapist invites the patient to tell her the reason for the visit. The patient starts with the history of how the problem started, continues with measures of intensity ("*after approximately 11 kilometers*" – line 11) and its consequences ("*Then the other day (.) I was only able to walk badly*" – line 13) before presenting her own understanding of what the problem was which got rejected by the doctor (line 13 – 14 and 16). At the end of the sequence the patient states her approach to this problem (to rest and only walk – line 18 and 19) and the outcome ("*but this actually did not help much either*" – line 22).

During this initial presentation of the patient's problem the therapist uses several continuers ("*↑Mhm*" - lines 5, 8, 12, 15, 17, 20) and an acknowledgment token ("*Yes*" – line 22) to signal receipt of the information. With the next extract I demonstrate how the therapist gets confirmation about her understanding when she summarises her findings shown in Extract 6.7 (14 minutes into the first session):

[91] Approximate translation: "*simply*"

Extract 6.7: B07 PTd Rx1_14.22

1 Physio	Gue::t (.) .hh aso jetzt hemmer- ebe eig- wenn i (.) das nomol tue zämefasse
	Goo::d (.) .hh so now have we- PART act- if I (.) this again do summarise
	Goo::d (.) .hh so now let's- *ebe*[92] act- if I summarise this once again
2	s'Jogge wos ebe meh uflöst vor allem 11-12 Kilometer 5-6 tuets liecht uslöse
	the jogging that it PART more triggers especially 11-12 kilometers 5-6 does lightly trigger
	the running which triggers it *ebe*[93] more especially after 11-12 kilometres after 5-6 it triggers it only slightly
3 Patient	**Mhm**
4	(0.2)
5 Physio	.hh Guet hettnech eigentlich s'Dehne toh und d'Wärmi
	.hh Good did you actually the stretching do and the heat
	.hh Good for you was actually the stretching and the heat
6 Patient	Mhm Ja.
	Mhm Yes.
7 Physio	Oder gits susch no öppis wo der chöit säge das tuet mer=
	Or is there otherwise still something that you can say that does me=
	Or is there still anything else you could say that it is=
8 Patient	Nei
	No
9 Physio	=guet.
	=good
	=good for you.
10 Patient	Das isch das
	That is this
	That's it
11 Physio	**↑Mhm**
12 Patient	S'einzige
	The only
	The only thing
13 Physio	Guet
	Good

The summary in Extract 6.7 includes the problem the patient was reporting on (running triggers pain – line 2) as well as what the patient tried at home to reduce the

[92] Approximate translation: "*even*"
[93] Approximate translation: "*even*"

pain (stretching and heat – line 5). The therapist enquires about further strategies that have helped the patient.

In my analysis of the previous two extracts, I point out that the main problem for the patient is that she is not able to go running without being bothered afterwards. Now, only a few minutes after Extract 6.7, the therapist enquires specifically about the goal, and the patient responds without delay.

Extract 6.8: B07 PTe Rx1_17.49

1	(3.2) *Therapist writes in her chart*
2 Physio	Guet (.) zum Schluss no vum Gspröch (.) üches Ziel? was möchted Ihr do (.)
	Good (.) at the end still of the discussion (.) your goal? what would like you here (.)
	Good (.) at the end of the discussion (.) your goal? now what would you like
3	[erreiche]
	[to achieve]
4 Patient	[Jo dass i eigentlich] cha unbeschwe(h)rt mim Sport ↑nochego[(h)oh hehe] .hh
	[PART that I actually] can caref(h)ree my sport ↑g(h)o a[(h)er hehe] .hh
	***Jo*[94] that I can actually follow my sport with no problems hehe .hh**
5 Physio	[Jo (.) guet]
	[Yes (.) good]
6	(0.9) ((*physiotherapist is writing in chart*))
7 Physio	[Aso bim Jogge] bliebe s[o]
	[So with jogging] stay s[o]
	So to continue with running like this
8 Patient	[Eh aso- eh] [Jo]:o aso .h ich has nocher echli mit Schwümme das isch tiptop=
	[Eh so- eh] [Ye:]es so .h I have afterwards a bit with swimming that is super=
	Eh so- eh Yes so .h I tried afterwards a bit of swimming that went super
9	=[gang]e sobald i (.) Ding wegnimme- (.) Schwümme hät notürli au wieder ge-ge- =
	=[wen]t as soon I (.) thing away took- (.) swimming has certainly as well agai- agai-=
	as soon as I (.) took the thing away (.) swimming is certainly as well agai- agai-=
10 Physio	**[↑Mhm]**
11 Patient	=isch wieder schwärelos ↑od[er]
	=is again weightless ↑isn'[t it]
12 Physio	[Mhm] ja
	[Mhm] yes

[94] Approximate translation: "*well*"

The first thing to notice is how rapidly the patient responds to the goal enquiry, that is, in overlap with the end of the therapist's turn. However, even though the response is uttered in overlap, there are some features that make the response less than straightforward: *well*-prefaced (see Section 5.2.2), laughter (line 4). The patient presents her goal as something that seems obvious, and the laughter might be related to the fact that they have been talking about the problem with running from the beginning of the session. I argue that the interactional difficulties are related to the fact that this (obvious) question should not need to be asked, and the patient orients to that here. In line 5, the therapist acknowledges this goal both verbally ("*Yes (.) good*") and bodily by writing it in her chart. When she retakes the floor with a formulation in line 7 ("*So to continue with running s[o]*") it happens in overlap with the patient who then abandons her turn but picks it up again just at the end of the therapist's utterance. The formulation uttered by the physiotherapist draws on prior talk implying that "*sports*" means "*running*". Through formulations then, a therapist can draw on information from different parts of the history-taking phase (see Chapter 4). By doing so, the therapist can show that s/he heard and understood the patient's concern as well as reshape the original response of the patient to the goal enquiry into a response 'acceptable' for physiotherapy.

In the previous examples I have shown how patients' initial goals are recast by therapists. While the patient proposes one goal, the therapist uses her knowledge from prior discussions to specify this goal. As this newly suggested goal is based on the patient's narrative, it can accomplish two things: first, the goal may be specified in order to serve the purpose of documentation (and reassessment), and second, it shows that the therapist has been listening and registering the patient's concerns. Formulations therefore help shape the goal into a format that is useful for physiotherapy as well as reuse the patient's words as closely as possible in order to demonstrate understanding.

The next section takes this process a step further by analysing the practice in which therapists in collaboration with patients transform initial goal statements into therapeutically acceptable goals.

6.2.3. Transformation of goals

In four cases of my data, therapists not only use formulations but pursue the patients' responses further to come up with a goal which is qualitatively different, or as discussed before, the new goal is a 'transformed conversational object' (Hester and Hester, 2012). In this case, we cannot talk of formulations of goals but rather of goal transformations. Transformations of goals require additional effort from participants as the sequences are often prolonged and include many more turns.

In the next example, I present a case in which the goal gets transformed through pursuit of the patient's response and how a physiotherapy-relevant goal is jointly achieved. Presenting the goal episode in four different parts, I demonstrate how the trajectory of goal definition has its origin in the problem presentation (Extract 6.9), how it is pursued in the summary (Extract 6.10) until finally it resurfaces in the goal setting sequence (Extract 6.11 and 6.12)

The first extract (6.9) is taken from the beginning of the first consultation. The therapist enquires about the patient's own view of her problems caused by a whiplash injury.

Extract 6.9: B10 PTg Rx1_3.02

1 Physio	Guet. (.) können sie mir (.) sagen was aus ihrer Sicht jetzt (.) das Problem ist was sie-
	Good (.) could you me (.) say what from your sight now (.) the problem is what you-
	Good (.) could you (.) tell me from your point of view now (.) what the problem is that you-
2 Patient	Aso ich ha Schwindelafäll Chopfweh und schlecht.
	Well I have dizziness headache and nausea
	Well I feel dizzy I have a headache and feel nauseous
3	**(0.4)** *((Physiotherapist starts to write in chart))*
4 Physio	Sie haben Schwindelanfälle Kopfweh und es ist ihnen übel also schlecht
	You have dizziness headache and it is you bad well nauseous
	You feel dizzy have a headache and you feel bad well nauseous
5	**(0.3)**

6 Physio Ja.

Yes.

7 **(3.5)** *((Physiotherapist continues writing))*

8 Physio **↑Mhm**

9 (7.2) *((Physiotherapist finishes writing and looks at patient before starting to talk))*

10 Physio Gehen wir mal der Reihe nach durch.

Go us even the row after through

Let's go through one thing at a time

11 Patient **Hehehe**

The patient responds to the therapist's enquiry immediately by presenting three problems: dizziness, headache and nausea (line 2). The therapist uses repetition (line 4) to indicate receipt, and the repairs from "*you feel bad*" to "*nauseous*" show the sensitivity to the patient's own words. As "*feeling bad*" is not the patient's description, but a kind of a formulation, the therapist adds this expression to a more 'recipient-designed' repetition.

The three main symptoms the patient describes as problematic - dizziness, headache and nausea - get introduced again by the end of the first consultation. The therapist has undertaken a full history-taking exam as well as the physical examination and arrives at the end of the assessment with a summary in which he recasts the patient's problems presented in the beginning.

Extract 6.10: B10 PTg Rx1 40.45

1 Physio Guet. (.) wenn ich jetz mal so ein bisschen zusammenfasse (.)

Good (.) if I now once such a bit summarise (.)

Good (.) if I summarise a bit (.)

2 dann könne wirs ja- vielleicht so ein bisschen auch mal einen Eindruck (besitze) (.)

then could we it so- probably such a bit as well even an impression (have) (.)

then we could so- probably just a bit get the impression (.)

3 aso das primäre Problem ist wirklich so wie sie dies in der Reihenfolge schon fast genannt haben=

so the primary problem is really as how you it in the order just nearly said have=

so the main problem is really as you have said it in this order

4	ist ein Schwindelproblem ja?
	is a dizziness problem yes?
	is a problem of dizziness right?
5	(0.2)
6 Patient	Ja
	Yes
7	(0.2)
8 Physio	und der Kopfschmerz und vor allem die Übelkeit hängen hintendran.
	and the headache and especially the nausea hang behind on it
	and the headache and especially the nausea are connected to it
9 Patient	Ja.
	Yes
10 Physio	genau gesagt Kopfweh geht wie in Schwindel über
	correctly said headache goes like in dizziness over
	to say it correctly the headache leads to dizziness
11 Patient	Jawohl
	Exactly
12	(0.8)
13 Physio	**Mhm**

Looking at this extract we see that the same three symptoms are presented in the same order they were in the beginning of the consultation: dizziness, headache and nausea. By using a tag question after the main problem, "*dizziness*" (line 4), the therapist invites the patient to confirm this first symptom, which the patient promptly does. In line 8, the therapist continues to present the other two symptoms by indicating that they are related to the main symptom (*and*-prefaced in line 8, specified in line 10), which again is confirmed swiftly by the patient.

While these two extracts closely resemble Extracts 6.6 and 6.7, the goal setting sequence that follows is quite different. In extracts 6.11 and 6.12 I show how further questions and formulations can transform a goal into a different category. I divided the long sequence in Part 1 (Extract 6.11 - formulation) and Part 2 (Extract 6.12 - transformation) in order to make it easier to follow my argument. In line 8 the therapist initiates the process, followed by a response given by the patient in a straightforward manner.

Extract 6.11 : B10 PTg Rx2 4.22 – Part 1

8 Physio	Die nächste Frage ist ↑die (.) was erwarten sie von der Therapie im Moment.
	The next question is ↑this (.) what expect you from the therapy at the moment.
	The next question is this one (.) what do you expect from therapy at this time
9	was ist ihr Ziel. was möchten Sie erreichen.
	was ist your goal. what would like you to achieve.
	what is your goal. what would you like to achieve.
10	(0.9)
11 Patient	Dassi mini Bewegige wieder cha mache
	That I my movements again can make
	That I can move again
12	(2.0) *((physiotherapist is writing in his chart))*
13 Physio	Ihre Bewegungen das heisst?
	Your movements that means?
	Which means that you can move again?
14	(0.2)
15 Patient	Auso dass mer ned immer wieder schwindlig wird
	So that me not always again dizzy get
	So that I don't get dizzy all the time
16	(0.7)
17 Physio	**↑Mhm**
18	(1.4)
19 Patient	>Dass i nüme so igschränkt bi<
	>That I not any more so restricted am<
	That I am not so restricted anymore
20	(2.9)
21 Physio	Also weniger Schwindel.
	So less dizziness.
	So less dizzy.
22 Patient	Ja
	Yes
23	(0.7)

This extract illustrates nicely how the therapist orients to certain (physiotherapy-related) information while he does not attend to other kinds of information. The patient responds to his goal enquiry with a straightforward response (line 11 – *"That I can move again*"). After a pause in which the therapist writes in his chart, he further enquires what "*movement*" means. The patient then specifies first with "*less dizziness*" (line 15), which

is minimally acknowledged by the therapist ("*↑Mhm"* – line 17). After a pause, the patient adds additional information "*That I am not so restricted anymore*" (line 19). This response somehow relates to her first goal statement ("*that I can move again*" – line 11). When the physiotherapist starts his '*so'*-prefaced formulation, he does not refer to just the prior turn (line 19), but picks up on "*dizziness*" (line 15), the first item of the list, which is the norm in mundane conversations (Jefferson, 1990). As mentioned earlier, "*also*" ("*so*" in English) is the most common linguistic device for formulations in German (Deppermann, 2011).

Although this formulation is confirmed by the patient and could, therefore, be the end of the sequence, it is only an intermediary step for the therapist. The therapist pursues the response further and transforms the initial response into a documentable, physiotherapy-specific goal, using a hypothetical question to initiate this sequence.

Extract 6.12 : B10 PTg Rx2_4.22 – Part 2

24 Physio	Wenn Sie weniger Schwindel (.) ↑hä□en (.) was würden Sie dann machen.
	If you less dizziness (.) ↑had (.) what would you then do.
	If you were less dizzy what would you do then.
25	(1.3) *((Physio continues to look at the patient until patient starts to speak))*
26 Patient	De würdi (.) d'Sache wieder schneller mache
	Then would I (.) the things again faster make
	Then I would do things faster again
27	(1.0)
28 Patient	D'Arbeit schneller mache
	The work faster make
	Do the work faster
29	(0.8)
30 Physio	Zum Beispiel Betten (.) schneller m[achen oder was]
	For example beds (.) faster m[ake or what]
	For example to make the beds faster or what
31 Patient	[Ja oder] jo
	[Yes or] yeah
32	(0.4)

33 Patient	D'Chuchiarbeite-
	The kitchen work-
	The kitchen work
34	(1.0)
35 Physio	Im Moment sind Sie langsam
	At the moment are you slow
	At the moment you are slow
36 Patient	Jo de machi immer [alles] längsämer
	Yeah then do I always [everything] slower
	Yeah I do everything slower all the time
37 Physio	**[Mhm]**
38	(2.4)
39 Physio	Also Ihren Haushalt (.) quasi schneller [(.)] über die Runden bringen ↑mhm
	So your household (.) like faster [(.)] over the rounds bring ↑mhm
	So to do your housework faster mhm
40 Patient	[Ja]
	[Yes]

The transformation sequence starts with a hypothetical question ("*if you were less dizzy what would you do then*" - line 24). Hypothetical questions, a particular type of conditional questions, can be used to test the commitment and views of the interlocutor (Speer, 2010 and 2012). In line 26 the patient responds with "*then I would do things faster again*", which she clarifies herself by replacing "*things*" with "*work*". Again, it is the therapist who pursues this matter further by proposing that "*work*" could mean "*make the beds*" (line 30), but he keeps the door open for other suggestions ("*or what*"). It seems evident that the therapist's suggestions are more specific and more 'assessable' and would therefore fit an overarching theoretical framework of goal setting (Scobbie et al, 2011). In line 31 the patient confirms that to "*make the bed*" is one activity, but expands it further ("*the kitchen work*" - line 33). The declarative question (line 35) invites confirmation, which is immediately forthcoming; however, it is also upgraded by the patient by expanding to all activities ("*everything*") and covering an unlimited timeframe ("*all the time*"). The formulation uttered by the therapist is *so*-prefaced and takes into consideration the step-wise elaborated activities summarised as "*housework*" and the speed ("*faster*" – line 39) in which they are accomplished. Looking at this example, we

see how the initial response given by the patient ("*that I can move again*" – line 11) gets transformed over several turns until it gets formulated by the therapist ("*to do your housework faster*" – line 39).

The next example presents a patient who has been referred to physiotherapy services for her chronic back pain. I demonstrate that the physiotherapist uses the hypothetical question in a way that is similar to Extract 6.12. Yet, what I show in this pursuit of response is that the patient herself orients to the need for clarification of the goal. The pursuit does not happen in the first consultation, but in the beginning of the second consultation. In the first part, I present the goal enquiry (in the first consultation) to which the patient give an initial response (Extract 6.13). This extract is followed by Extract 6.14 in which the patient comes back for the second consultation and presents her reflection about those goals.

Extract 6.13: B18 PTb Rx1_19:50

1 Physio	Was würded Ihr gern erreiche? (.) oder was wär sochli d'Erwartig ad Physiotherapie für Euch?
	What would you like to achieve? (.) or what would be a bit the expectation for physiotherapy for you?
	What would you like to achieve? or what would be a bit about what you expect from physiotherapy?
2	(2.0)
3 Patient	I wett eigentlich das erreiche dassi mal (.) ohni Schmerze chönnt si
	I would like actually this to achieve that I once (.) without pain could be
	I would actually like to achieve that I would be for once pain free
4 Physio	**↑Mhm**
5	(3.0) *((Physiotherapist turns to write in chart, patient retakes floor while therapist is still writing))*
6 Patient	Das wär eigentlich mis- mis Ziel alles andere isch mir im Pri(h)nzip gliech (.)
	This would be actually my- my goal everything else is me I n pri(h)ncipal unimportant (.)
	This would actually be my- my goal everything else is principally unimportant to me
7	ich wett eigentlich nume mal (1.0) ohni (.) Schmerze si
	I would like actually only once (1.0) without (.) pain to be
	I would actually like to be just once (1.0) without pain
8 Physio	Ganz ohni Schmerze [ja] ((*therapist starts talking while still writing*))
	Totally without pain **[yes]**
9 Patient	[Genau]
	[Exactly]

10 Physio	Was würded ihr denn mache wenn das mol so wär?	
	What would you then do if this PART like this were?	
	What would you do if it were *mol*[95] like that?	
11	(1.0)	
12	Was wär s'erschte woder miechted?	
	What would be the first that you did?	
	What would be the first thing you did?	
13	(1.0)	
14	[wenn der keini Schmerze meh hätted?]	
	[if you no pain anymore had?]	
	if you were without pain?	
15 Patient	[Gliiech wie jetzt]	
	[Same as now]	
16 Physio	Ja	
	Yes	
17 Patient	Aso eifacht ruhiger si echli [meh gniesse]	
	So MOD more quiet be a bit [more to enjoy]	
	So *eifacht*[96] to be quieter to enjoy a bit more	
18 Physio		[E Stund länger schlofe] ja (.) ja
		[One hour longer sleep] yes (.) yes
		To sleep one hour longer yes (.) yes
19 Patient	Ja	
	Yes	

The therapist in this extract enquires about the goal by asking the patient first about what she would like to achieve (line 1) immediately followed by a second "*or*-prefaced" question: "*or what would be a bit about what you expect from physiotherapy?*". This is a very carefully phrased question, including a conditional ("*would be*") and a minimiser ("*a bit*"). The patient's response is not immediately forthcoming. After a two second pause, the patient states that she would like to be without pain (line 3 – "*I would actually like to achieve that I would be for once pain free*"), linking the response to the first part of the question (about achievement). This response is vocally acknowledged ("↑*Mhm*" – line 4) and ratified by the therapist in an embodied way (line 5 – writing). In line 6, while the therapist is still writing, the patient

[95] Approximate translation: "*once*"
[96] Approximate translation: "*just*"

retakes the floor and reiterates her goal ("*This would actually be my- my goal*") by stating it more explicitly: "*I would actually like to be just once (1.0) without pain*" (line 7). This goal enquiry shows once again that participants consider 'goal', 'achievement' and 'expectation' as synonyms.

In line 8 the physiotherapist repeats and modifies the patient's proposed goal by upgrading the patient's expression of "*without pain*" (line 7) to "*totally without pain*". The patient confirms this statement, which then leads to the physiotherapist's next question (line 10 – "*what would you do if this were like that*"). As in Extract 6.11, the physiotherapist uses a hypothetical question to elicit a specific activity that would be easier if the patient were not in pain. However, the response is not forthcoming and the therapist pursues the topic (line 12 - "*what would be the first thing you did*"). Again, the patient does not respond immediately, and the physiotherapist adds the second part of the conditional question ("*if you were without pain*" – line 14) which is then responded in overlap by the patient. The patient's proposal in line 17 ("*So eifacht to be quieter to enjoy a bit more*") is then transformed by the physiotherapist to "*To sleep one hour longer yes (.) yes*" (line 18). The therapist's final statement is accepted by the patient in line 19 with a "*Yes*" and with this action the sequence is closed down.

It is interesting to note that the patient comes back to this in the second consultation and refers to this first goal discussion just shown above. As the follow-up discussion in the second consultation is a lengthy episode, I divided the sequence into different parts: Part 1 (Extract 6.14) shows the patient's goal statement, Part 2 (Extract 6.15) presents the patient's presentation of what she cannot do, and Part 3 (Extract 6.16) exemplifies the therapist's contribution to the goal proposal.

Extract 6.14: B18 PTb Rx2 7:01 – Part 1

1 Physio	.hh Aber wenn is richtig verstoh giengs dem Fall würlich drum dass mer es globals Training=
	.hh But if I it right understand would be the case really the reason that we a global training=
	.hh But if I understand correctly it would be in that case the reason that we had afterwards a
2	=nächene hätte [schlussendlich]
	=afterwards would have [at the end]
	global training schedule at the end
3 Patient	[Jawohl]
	[Yes]
4 Physio	Auso
	Okay
5 Patient	Und eifacht ebe mis Ziel woder mi s'letscht Mol frogt [hend]=
	And MOD PART my goal that you me the last time asked [have]=
	And *eifacht*[97] *ebe*[98] my goal that you asked me about the last time=
6 Physio	**[↑Mhm]**
7 Patient	=das wär eigentlich (.) as mir de Schmerz nüme mis Lebe bestimmt sondern (.) ig (.) mis=
	=that would be actually (.) that me the pain not anymore my life controls but (.) I (.) my=
	=that would actually be that the pain does not control my life anymore but that I control
8	=Lebe selber cha bestimme [oder] =
	=life alone can control [huh]=
	my life again by myself huh
9 Physio	[Ja]
	[Yes]
10 Patient	=und wieder cha mache wini- will (.) ich ha mir nochher au überleit es isch mir gar nie=
	=and again can do as I- would like (.) I have me afterwards also thought it is me never ever=
	and I can do again as I- wish (.) I thought about it afterwards I was never ever conscious
11	=bewusst worde >ich ha scho soviel ufgeh<
	=conscious get >I have already so much up give<
	about the fact that I gave up already so much
12 Physio	**Mhm**
13 Patient	[Oder]
	[Huh]
14 Physio	[När]
	[Afterwards]

[97] Approximate translation: "*just*"
[98] Approximate translation: "*even*"

I would like to draw attention to two things covered in prior sections. First, the patient initiates the goal setting sequence (line 5) and makes reference to what the therapist asked the last time, thereby accounting for this move. By using an *–and-* prefacing, the patient orients to a link between what has been exchanged previously and what is about to come (see Section 4.2.2). Second, the use of the modal particle "*eifach*" (line 5 – see Section 5.2.3) and the tag question in line 8 (see Section 5.2.2) indicates her orientation to the epistemic contingencies. In lines 10 and 11 she states that the question made her think differently about what she had to give up lately because of the pain. The therapist acknowledges only minimally the patient's statements at this point.

I show with this extract that, in fact, the patient went home after the first consultation and took the opportunity to come back with a goal statement. My observation is in line with Rapley's (2008) argument that decision-making is an "ongoing event". In this case, the goal setting activity is carried over to the follow-up consultation. I have argued in Chapter 4 that physiotherapists' assumption embedded in their goal enquiry is that goal setting is an independent activity. With this extract I show that goal setting is in fact an interactional achievement and goals are mutually constructed.

The following extract gives a description of the patients' difficulties and how she had to change her life to adjust to her pain, and thereby accounting for her goal "*that the pain does not control my life anymore*" (Extract 6.14 - line 7).

Extract 6.15: B18 PTb Rx2_7:01 – Part 2

15 Patient	I gang nie furt ich mach nüt ab=	
	I go never out I make nothing up=	
	I do not go out I do not plan anything	
16 Physio	Ja ja	
	Yes yes	
17 Patient	=i gang nümm go Töff fahre ich ha mi Spinnezucht ufgeh=	
	=I go never to motorcycle ride I have my spider rearing up give=	
	I do not ride my motorcycle anymore I gave up my spiders	

18 =[eifa]cht extrem viel aber irgendwie tueni- jo ich ha mich nie mit däm-

=[MOD] extremely a lot but somehow do I- PART I have me never with this-

eifacht[99] **extremely a lot but somehow I do-** ***jo***[100] **I have never with it-**

19 Physio **[Mhm]**

20 Physio Ja isch das eifacht wie dominanter worde gäng de Schmerz [wo=]

Yes is this MOD like more dominant get always the pain [that=]

Well the pain ***eifacht***[101] **got more dominant that it has**

21 Patient [Genau]

[Exactly]

22 Physio =eifacht gäng echli meh Kontrolle übercho übers lebe ja .hh das isch sicher=

=MOD always a bit more control get over the life yes .hh this is sure=

eifacht[102] **gotten always a bit more control over your life yes .hh this is indeed**

23 =ganz es guets Ziel .hhh [und-]

=totally a good goal .hhh [and-]=

a very good goal .hhh and-

24 Patient [Und] ned numme eifacht- jo de Schmerz weg [oder]

[And] not only MOD- PART the pain away [huh]

And not only ***eifacht-***[103] ***jo***[104] **the pain away huh**

25 Physio [Ja]

[Yes]

26 Patient Eifacht- i wett eifacht wieder chönne (.)

MOD- I would like MOD again could (.)

Eifacht-[105] **I would like** ***eifacht***[106] **again (.)**

27 Physio Genau

Exactly

28 Patient selber bestimme im Prin[zip]

by myself decide in princi[pal]

to decide by myself in principal

29 Physio **[Mhm]**

---

[99] Approximate translation: "*simply*"
[100] Approximate translation: "*well*"
[101] Approximate translation: "*just*"
[102] Approximate translation: "*just*"
[103] Approximate translation: "*just*"
[104] Approximate translation: "*well*"
[105] Approximate translation: "*simply*"
[106] Approximate translation: "*just*"

The description in lines 15, 17 and 18 includes several activities that are difficult for the patient to achieve. She explains that she has already given up a lot because of her back pain. By presenting not just one problem, but many activities, the patient exemplifies how much she is bothered in her life by her pain ("eifacht *extremely a lot*" - line 18). The therapist then comes in (line 20) and utters a formulation ("*the pain has just gotten more dominant it has just gotten always a bit more control over your life*" - line 20, 22). This proposal can be linked back to the patient's initial goal statement (line 7 and 8 in Extract 6.14), and it is then followed by the therapist's evaluation of the stated goal ("*yes .hh this is indeed a very good goal*" – line 22 and 23). While formulations in previous examples were commonly initiated using "*so*", this one starts with a "*ja*" (translated as "*well*"). Quite often formulations function as turn-closing device, however, in this case the patient continues after the therapist's formulation. She makes another goal statement (line 24) that it is not only about pain relief (line 24 - "*And not only* eifacht jo *the pain away*"), but that she would like to decide by herself (line 28). Even though the patient constructs her talk as knowing what she would like, she still presents her goals very carefully. By describing what she had to give up (lines 15 – 18), by using "*eifacht"* (line 18, 24, 26) as a way to make the reasons self-evident (see Section 5.2.3) and by using tag questions (line 24) to convey uncertainty (see Section 5.2.2).

In Part 2 the patient builds her argument with a range of resources, and I will show with Part 3 how the therapist continues to close down the goal sequence. It is presented in a way for the patient to be able to confirm the proposed goal.

Extract 6.16: B18 PTb Rx2 7:01 – Part 3

30 Physio Ich denke das isch es guets Ziel vor allem wills ebe de Aspekt dinne het mir chöi ned de=
I think this is a good goal especially because it PART the aspect in it had we could not the=
I think that this is a good goal especially because it is *ebe*[107] the aspect we cannot *eifacht*[108] take away

31 =Schmerz wahrschienlich vu hüt uf morn eifacht wegneh auso de Schmerz wird sicher die=
=pain probably from today to tomorrow MOD take away so the pain will surely the=
the pain probably from today to tomorrow so the pain will certainly belong to you for

32 =nöchschti Ziet dezue ↑ghöre .hh d'Frog isch eifacht ebe wie gömmer mit dem um?=
=next time to it ↑belong .hh the ques□on is MOD PART how go we with this on?=
a time .hh the question is *eifacht*[109] *ebe*[110] how do we deal with it?=

33 Patient **Mhm**

34 Physio =und was chöimer trotzem Schmerz ebe mit echli meh Kontrolle oder ebe au .hh mitere=
=and what can we despite the pain PART with a bit more control or PART as well .hh with a=
and what can we try afterwards despite the pain *ebe*[111] with a bit more control or *ebe*[112] as well .hh=

35 =andere Istellig probiere nächene=
=other attitude try afterwards=
with another attitude

36 Patient Jawohl
Yes

37 Physio =trotzdem wieder echli meh vum lebe zha (.) [he?]
=despite again a bit more of the life to have (.) [huh?]
to have again a bit more from life despite of the pain (.) huh?

38 Patient [Genau]
[Exactly]

39 Physio .hhh Auso [aber de-]
.hhh So [but then-]

40 Patient [Jetzt tueni] mental amel wenn i is Bett go oder so bevor i schlo- tuen i immer- (0.4)
[Now do I] mentally whenever when I to bed go or so before I slee- do I always (0.4)
Now I do some mental exercises whenever I go to bed or so before I slee- I always do (0.4)

41 dass mer so vorsäge oder dass mi (.) d'Chrankheit ned cha beherrsche=
that me so recite or that me (.) the illness not can control=
that I say to myself or that the illness does not have control over me

---

[107] Approximate translation: "*even*"
[108] Approximate translation: "*just*"
[109] Approximate translation: "*simply*"
[110] Approximate translation: "*even*"
[111] Approximate translation: "*even*"
[112] Approximate translation: "*even*"

42 Physio Ja

Yes

43 Patient =de Schmerz chasch mi ned beherrsche=

=the pain can you me not control=

the pain you don't have control over me

44 Physio [Ja]

[Yes]

45 Patient [=eso] viellicht tuets jo-

[=PART] probably does it PART-

***eso*[113] probably this does *jo*[114]-**

46 Physio ↑Jo das isch guet

↑Yes this is good

In line 30 the therapist starts the closing sequence by stating "*the good goal*" followed by an explanation that resembles an advice giving sequence. The therapist's question in line 32 *(".hh the question is* eifacht ebe *how do we deal with it?")* does not require a response, but is acknowledged by the patient (line 33 – "*Mhm*"). The therapist continues by putting emphasis on a collaborative effort (line 34 – "*and what can we try afterwards despite the pain* ebe *with a bit more control*" and in line 35 "*with another attitude*"). This is where the transformation happens from the patient's statement "*to get more control over her life*" to the therapist's proposal of "*we can try afterwards despite the pain with a bit more control and another attitude*".

Acknowledged by the patient (line 36 and 38), the therapist then starts a '*so'*-prefaced utterance but abandons it in line 39. The patient comes in in overlap and describes what type of mental exercises she does before going to bed. This statement is acknowledged by the therapist (line 42 and 44 – "*yes*") and then evaluated "*Yes this is good*".

This last example shows the complexity of goal setting accomplished in interaction. The three-part goal episode (Extracts 6.14 – 6.16) emphasises the work participants do to achieve goals acceptable to both participants. While in Part 1, the

[113] Approximate translation: "*like this"*
[114] Approximate translation: "*well*"

patient introduces her goal in a careful way, she then adds more assertions by providing more reasons to feel that way (Part 2) until they mutually agree in Part 3 on a 'transformed goal' which is qualitatively different from the one presented in the beginning.

I have shown in this findings section that patients do participate only minimally in goal setting if therapists use response tokens in reply to patients' initial goal statements. Yet, if therapists use repeats and formulations, patients treat this moment as an opportunity to elaborate further. I show, therefore, that goals are not pre-set entities but are elaborated and negotiated during interaction with the help of repeats and formulations. Using formulations gives therapists an opportunity to demonstrate that they have heard and understood patients. Finally, transformation is a less frequent practice; however, it is highly interactive and is concluded with a jointly produced physiotherapy-acceptable goal. Transformations are present when goals are qualitatively different from the initially stated goals and are achieved through a collaborative process. Table 6.1 gives an overview of the different practices presented in this Chapter.

Table 6.1: Summary of practices of follow-ups to initial goal responses

Response tokens (4/14)	**Repetitions or partial repeats (7/14)**	**Formulation (7/14)**	**Transformation (4/14)**
B04	B06	B03	B10 (with HQ)
B08	B07	B06	B18 (with HQ)
B11	B08	B07	B19
G02	B09	B09	B20
	B10	B16	
	B18	B19	
	G05	G05	

Legend: HQ = hypothetical question

6.3. Discussion

My analysis in this chapter has shown how patients' responses to therapists' goal enquiries are followed up. I identified four different practices: from therapists' using response tokens and repetitions or partial repeats to signal receipt of information, to formulations and transformations of goals, which function to shape and reshape goals into therapeutically relevant forms by orienting to prior exchanged information. In addition, I have demonstrated that which of these resources is used has a relationship with the phase of the consultation in which the goal enquiry takes place (in the beginning vs. towards its end) and with the type of goals that the patient has proposed (functional activities vs. vague goals).

I have shown that when therapists mainly use response tokens, patients do not talk at length about goals or related topics. I have further shown that repetitions or modified repeats function similarly to response tokens, but encourage patients to talk at greater length. By repeating partially or fully patients' responses, therapists not only indicate the receipt, but patients orient to the repeating of their responses as an invitation to expand on the same topic or elaborate further related topics.

The third practice described in this chapter is the therapists' use of formulations to either draw on prior talk, thereby prioritising certain information that is relevant for goal setting, or to propose a more specific goal and thereby interpreting patients' proposal. Formulations by therapists project agreement (Heritage and Watson, 1980), but are not the only practice to do so.

The last practice explored in this chapter is when therapists in collaboration with patients transform the initially stated goal to a goal acceptable for physiotherapy. The transformation includes a shift from an initial goal description ("*less dizzy*") to a qualitatively different endpoint ("*to do the housework again*"). One resource therapists use to accomplish transformation is posing hypothetical questions - these can not only elicit views (Extract 6.12) but can also incite patients to rethink their goals (Extract 6.13 and 6.14).

I have also shown that the transformative process does not necessarily only take place in one consultation but can be carried over to follow-up consultations (Extract 6.13 and 6.14). In line with Rapley's (2008) argument that decision-making is not "just a solo, cognitive activity" (p. 429), I have shown that the goal setting process is mutually constructed and not – as theories suggest – set up in advance.

In sum, I demonstrate in this chapter that when therapists primarily use response tokens (mostly "*mhm*"), the activity of goal setting is confined to documenting a goal, and patients do not elaborate further on the topic. However, a difference has to be made between "*mhm*" with a rising intonation and "*mhm*" with a falling intonation (Gardner, 2005). While "↑*mhm*" is treated by patients as a continuer, a falling intonation tends not to elicit much further talk. I argue that this response token functions mainly as an acknowledgment of receipt of a response.

Repetitions or modified repeats have a function similar to response tokens. When therapists repeat fully or partially the patients' response, they indicate that they have registered the information. Repetitions are frequently combined with acknowledgement tokens or formulations.

When therapists use formulations to summarise goals, they do so by drawing on previous discussions and showing patients that they have been listening to their talk by linking goals to problems presented earlier and thereby making the goal more fitted to the matters raised by the patient (Hutchby, 2007). Through the use of this device, therapists also reshape goals into a format that is useful for their professional practice, namely to have function-oriented goals. Formulations also work as a way to close down the goal discussion and to move on to the next topic. These functions have already been described in other therapeutic settings (Antaki, 2008).

The final practice used as a follow-up to initial patients' responses involves therapists *transforming* patients' initially stated goals. The longest goal discussions in my data are the four cases in which goals are transformed through talk, meaning that the goal as expressed at the endpoint of the discussion is qualitatively different to the

patient's initial goal suggestion. This transformative process can be accomplished by using hypothetical questions. Speer (2012) describes hypothetical questions as resources to "expand rather than initiate a course of action" (p. 370). In her detailed analysis, she describes four types of hypothetical questions that attempt to have the co-participant reconsider a response: reverse contingency, a best-case scenario (this is the category where my examples fall into), a worst case scenario or one that removes barriers. Speer (2012) concludes that hypothetical questions can be of value in institutional settings "where recipients' views and commitments may otherwise be hard to access, pin down, or assess" (p. 371). The transformation process provides further demonstration of the nature of goals: they are not just entities in patients' heads that can be delivered when asked for, but that goals are matters that get collaboratively worked out, to varying degrees, culminating in jointly negotiated goals which seem compatible with physiotherapy practice.

Chapter 7: Discussion and future directions

7.1. Introduction

In this thesis I have argued that goal setting should be investigated from an interactional perspective and have reported on a study conducted using this perspective. In this final chapter, I summarise my findings and discuss them in the light of the literature reviewed in Chapter 2 and also in terms of the contributions they make to the fields of sociology, CA and the physiotherapy practice. After considering some of the study's limitations and some avenues for future research studies, I draw some conclusions. This thesis provides the foundation for goal setting to be understood as an interactive achievement where patients and physiotherapists negotiate their knowledge claims on a turn-by-turn basis.

7.2. Thesis Summary

In Chapter 2 I reviewed the literature on clinical-decision making, patient-centred care and goal setting, and explained that goal setting concepts are based on the premise that human behaviour is influenced by the person's perceived importance of a stated goal and her/his confidence to be able to attain that goal (Latham and Locke, 2007). While most of the evidence on goal setting is based on a cognitive-behaviourist approach (Scobbie et al, 2009), I made the case that we need to look at interactional aspects in order to more fully understand how goal setting works in practice.

Through examining previous studies that have investigated patient-professional interaction, I concluded that research in this field has relied predominately on quantitative methods in which researchers code and count interactional dimensions in patient-health professional encounters. I discussed the limitations of this approach, such as the non-consideration of interactivity (Heritage and Maynard, 2006a) and the overly broad definition of categories; I proposed that a solution to those limitations is offered by CA. Using a CA approach, the focus can be on intersubjectivity (Heritage, 2005), which is key to patient-health professional interaction.

In Chapter 3 I presented the rationale behind using CA as the method of choice. CA provides tools that can overcome the limitations inherent to 'code and count' (quantitative) approaches. I then provided details of the empirical aspects of the study (Section 3.5) in order to make the research process as transparent as possible. This detailed information, including the presentation of study settings, participants, and analytic principles, helps the reader understand how I undertook the study.

Chapter 4, 5 and 6 are the analytic chapters. Chapter 4 detailed my examination of the overall structure of the physiotherapy consultations and then focused in upon the questions posed by therapists to enquire about goals. In Chapter 5 I report my analysis of patients' responses to those questions; and in Chapter 6 I described in detail how the goal setting sequences unfold after patients' initial responses. The division into these three parts is in some ways artificial but it is necessary in order to adequately discuss the main arguments of this thesis. I turn now to the three key analytic themes arising from my study:

A. How physiotherapists enquire about goals by using *wh*-questions and the assumptions embedded in those questions
B. Goal setting is an interactional achievement, and involves epistemic dimensions
C. How physiotherapists respond to or transform patients' initial responses

7.2.1. Findings: How therapists enquire about goals, and the underlying assumptions of those enquiries

In Chapter 4 I examined how therapists enquire about goals. I showed that they treat goals as a standalone topic. I demonstrated that physiotherapists ask about goals in the same way as when they ask about straightforwardly factual matters, such as the patients' hobbies, or about subsequent appointment with doctors. In this way, therapists imply that goals are factual pieces of knowledge held, as it were, within the patient's head in the same way as information about temporal arrangements or their preferred pastimes. I argue that this conceptualisation is in line with the goal setting theories discussed in Chapter 2, and especially in line with Ryan and Deci's (2001) self-determination model. According to this model, it is assumed that patients pursue their

own goals until they master them, and therefore therapists can ask about goals, and patients can be expected to respond in a straightforward manner because their goals exist as (in a sense) factual entities within their heads. Aligning with this cognitive behaviourist approach, but differentiating between goal intention and goal pursuit, Scobbie et al (2009) divide the goal setting process in a motivational phase, where the intention to achieve a goal develops, followed by a "volitional phase in which the details of action are planned and the goal is pursued" (Scobbie et al, 2009; p. 329). In light of my results, however, there seems to be a mismatch between this cognitive behaviourist approach to goal setting and actual physiotherapy practice. I show the consequences of some of the interactional features and dimensions of question designs (*wh*-questions, assumptions embedded in therapists' goal enquiry), and the ways in which participants orient to those aspects of the interaction. The fact that patients do not always respond to goal enquiries in a straightforward manner, even though some may have experience with physiotherapy, tells us that there must be other interactional issues at stake. I argue that goal-setting is more complex than just 'digging into somebody's brain and picking out their goal' and is better understood as a social process with goals being mutually created and interactionally achieved.

I showed in Chapter 4 how goal setting is achieved in interaction, sometimes with and sometimes without difficulties. First, I showed some straightforward examples (Section 4.2.2) where it seems that therapists and patients share assumptions that patients have a goal (one goal, their goal) and that they are willing and able to articulate it. Participants in those examples orient to goal setting as to embedding assumptions along the lines of the cognitive behaviourist theories outlined above. Yet, in Section 4.2.3, it seems evident in the data that there are times when these assumptions are not shared – that is, patients do not respond in a straightforward manner with a goal, and interactional difficulties can arise. I showed that interactional resources such as laughter or accounting for (justifying) the goal enquiry are used to deal with those difficulties and to move on with the consultation.

In some recent literature on goal setting, it is recognised that the communicative difficulties of goal setting means that there needs to be a shift from 'rhetorical goal setting' to a new conceptualisation (Levack, Dean, Siegert and McPherson, 2011). In their study, Levack et al (2011) describe how clinicians privileged certain goals, favouring goals related to physical functioning and achievable in rather short timeframes (during the patient's rehabilitation stay), and goals using a "conservative estimate of progress" (p. 210). The authors conclude that if goals were to be set using a 'patient-centred approach', clinicians would have to discuss topics outside the traditional scope of goal setting (Levack et al, 2011; p. 212). According to my data, there seems to exist a discrepancy between how patients orient to goal setting and clinicians' practice. I was able to demonstrate that the challenge for goal setting lies in the mutual alignment between assumptions about goal setting, observable in the ways goals are elicited by therapists, and how patients respond to this enquriy.

The challenge of adequately conceptualising goal setting is quite similar to the difficulty of defining shared decision-making (Section 2.1.2). The analysis presented here provides evidence that those concepts, while laudable from an ethical standpoint (Wirtz et al, 2006) or on humane grounds (Guadagnoli and Ward, 1998), do not fit neatly into the social organisation of the physiotherapy encounters and can create interactional difficulties. As suggested by Heritage (2011), dysfunctional communication processes can be improved once clinicians understand the origins of practices and recognise their consequences. With my analysis, I show the assumptions that are embedded in the goal enquiries found in my data and what the consequences are when assumptions are or are not mutually shared by participants.

My findings in Chapter 4 conclude that goal setting is commonly treated as a separate topic of investigation, and that goals are treated as somewhat factual entities, pre-existing in the patient's head or mind. Yet, the discussion here proves that this way of understanding goal setting can be problematic. Interactional problems are evident where clinicians embed those assumptions into their goal enquiries, and patients do not

respond to those enquiries in a straightforward manner. Therefore, goal setting would be better understood if one were to incorporate evidence from studies such as this one, which recognise that questions are not neutral and can carry assumptions. As discussed, questions are resources not only for embodying assumptions, but also for conveying epistemic stance (Heritage, 2010). I discuss this matter in the next section.

7.2.2. Findings: Goal setting is an interactional achievement involving epistemic dimensions

As presented in Chapter 5, goal setting is an activity in which claims about knowledge become salient: people do not simply exchange facts or information when they communicate, but instead when they are communicating about knowledge, they construct their talk in ways as to show that they know something for sure, that they are uncertain about it, or something in between these two poles (i.e. they convey their access to knowledge); also they convey whether they have greater or lesser rights and responsibility to know (i.e. they convey their degree of authority with regard to knowledge). People use particular linguistic devices and practices to indicate these positions regarding access and authority. These matters have implications in terms of asymmetry related to knowledge and the normative ideas of partnership advocated in goal setting theories and policy papers.

I argue that managing knowledge in interaction is not simply a matter of exchanging information about goals; instead people orient to knowledge in their interactions in terms of the type of knowledge they are entitled to have, and how strongly they claim to know particular things. Heritage (2011) argues that "the distribution of rights and responsibilities regarding what participants can accountably know, how they know it, whether they have rights to describe it, and in what terms, is directly implicated in organized practices of speaking" (p. 182). I showed in Chapter 5 how issues of access to and authority over knowledge about goals are evident in the interaction. Through linguistic resources such as "*jo*"-prefacing, the particle "*eifach*" and the evidential marker "*I think*" within patient's responses, patients show how

participants "embody how they see information or knowledge to be distributed between them and the recipients" (Hayano, 2011; p. 58-59).

I have noted that findings illuminate patients' epistemic stance, i.e. access to and entitlement of knowledge about goals, and how it is conveyed. Epistemics is also related to the concept of 'status' as I suggested throughout Chapter 5. Enfield (2011) divided the concept of status into entitlements (what we may do) and responsibilities (what we must do) in relation to knowledge. A person's status is defined "as a collection of his entitlements (or rights) and responsibilities (or duties) at a given moment, relative to other members of his social group" (Enfield, 2011; p. 291). With the use of the evidential marker "*I think*" (Section 5.2.4), patients indicate that they treat their claim to knowledge about goals as weak. I argue that patients and indeed therapists construct their status within the details of the vocal and bodily aspects of goal setting sequences, and this forms part of a larger process of constructing (asymmetric) status.

There is a growing body of evidence from research on health professionals' interactions confirming that equal distribution is not achieved in interaction and that asymmetry persists in medical practice (Peräkylä, 2002), as well as in other health care interactions, such as in genetic counselling (Pilnick, 2002), health visiting services (Heritage and Sefi, 1992), pharmacy (Pilnick, 1998) and physiotherapy (Parry, 2004). This provides empirical evidence that asymmetries are therefore part of the very nature of the health professionals' work (Pilnick and Dingwall, 2011). While CA studies support claims that asymmetry is inherent, and argue that there are important functional reasons for its continued presence (Maynard, 1991; Pilnick, 1998; Roberts, 2000; Ariss, 2009), both goal setting literature and the literature about shared decision-making continue to focus on 'partnership' (Charles et al, 1999; Montori et al, 2006; CPO, 2009; Scobbie et al, 2011) or even 'equal partnership' to strive for (Ford et al, 2003). Given the empirical evidence of various CA studies, I argue that my study supports the claim that asymmetric interactions are related to differences in knowledge. Patients know intimately about the problems with their bodies, but might have limited knowledge

about how physiotherapy can help in improving those problems. Physiotherapists have expert knowledge about bodies in general from a professional perspective, but do not have access to the patient's singular experience. In my data, I found that both participants are very careful in making claims about the other's knowledge. In goal enquiries and patients' responses to those questions, patients and therapists orient to this delicate balance of what they know, what they are supposed to know and what knowledge lies in their domain. For instance, in cases in which the patients' responses are fitted to physiotherapists' enquiry about goals (straightforward responses), there is epistemic congruence, while the less-than-straightforward responses, where there is incompatibility of epistemic orientations, are epistemically incongruent (Hayano, 2011).

In summary, I showed that therapists' initial goal enquiries embody assumptions, and both these questions as well as patients' responses to them convey epistemic stance, telling us about their epistemic orientation.

7.2.3. Findings: How physiotherapists respond to or transform patients' initial responses

I started Chapter 4 by presenting the structure of the physiotherapy consultations. The question format of the goal enquiry did not differ much whether goals were elicited in the beginning of the consultation or later on (Table 4.1), but the location of the goal setting sequence did have an impact on the trajectory of goal setting that followed the initial response given by patients. When therapists enquire about goals early in the beginning of the consultation, they were not able to draw on previously exchanged information, but could only acknowledge receipt of the patients' response. However, if therapists initiated the goal enquiry at the end of the history-taking phase, at the end of the first consultation or during the second consultation, they were able to rely on information previously provided by the patient and were able to shape goals into physiotherapy acceptable (functional-oriented) goals. In Chapter 6 I differentiated between response tokens and repeats that were not followed by new content within the talk (Section 6.2.1), and formulations (Section 6.2.2) and transformations (Section 6.2.3) which are interactive resources inducing more talk. I have argued that the latter two

practices - formulations and transformations - help establish a mutual intelligibility of goals and require from the therapist a certain understanding of the reason why a patient seeks physiotherapy. Through the use of hypothetical questions (Section 6.2.3), therapists are able to question some of the patients' proposed goals without direct rejection. The practice of transformation can establish agreement through proposal and acceptance, making interaction necessary to come up with a goal.

Goal setting is not solely about eliciting patients' predetermined goals but about reaching consensus which culminates in the therapist recording a written measurable goal to be reassessed in future consultations. Goal setting is therefore a means by which therapists produce a record of a functional activity that lies in the patient's domain. Simply put, the practice of goal setting is as much about professional accountability as it is about 'patient-centred practice'. My findings contribute to better understanding the complexity of goal-setting and indicate the need to do more than prescribe the SMART goals (specific, measurable, attainable, relevant and timely) advocated in the rehabilitation literature (Bovend'Eerdt, Botell and Wade, 2009). I demonstrate that goal setting entails assumptions and epistemic dimensions that both parties orient to, and that interactional work, sometimes lengthy, is required to achieve goal setting. I therefore contribute with my findings to the understanding of how goal setting is actually accomplished in practice.

7.3. Contributions

7.3.1 Implications for sociology

My findings add to the growing body of evidence about how epistemics are salient in shaping interactions. I explore a less frequently analysed language (i.e. German) and an under-analysed profession (physiotherapy) from a sociological perspective. In Sections 7.2.1 and 7.2.2 I draw on ideas about self-determination and patient-centeredness and how these are played out in patient-physiotherapist interactions, showing, that it is problematic to assume that patients have an a priori notion of their goals, and that they will treat themselves as entitled to state them in this context. In today's society, it is difficult to take a standpoint which highlights limitations

of patient participation. However, by providing empirical evidence about what happens in goal setting sequences, and drawing from this an understanding of the complexity of applying concepts argued to accomplish 'patient-centredness', discussions can be opened between researchers, educators, practitioners and policymakers. Furthermore, my findings show that goal setting is not, as often suggested in the literature, an individual process, but an interactive achievement involving both participants.

7.3.1 Contributions to Conversation Analysis

First, my analysis provides insight from a conversation analytic perspective into a less frequently investigated language (German). I identified phenomena which are only starting to be investigated: German modal particles have recently begun to be analysed from a CA perspective (Barske and Betz, unpublished). This study provides a small addition to the understanding of the functions of German modal particles.

Second, I contribute to the knowledge of how goal enquiries are formulated and provide insight into the fact that both long and abbreviated versions of the question type "*what is your goal*" are similarly oriented to by participants. Investigation of question design and functioning, especially of Yes-No-Interrogatives, has been extensive, but *wh*-questions have been less often analysed. My findings have made some contribution to beginning to analyse responses to *wh*-questions. My data confirm previous findings (in other languages and settings) that *well*-prefacing (or rather the German "*jo*"-prefacing) indicates that responses that follow are less than straightforward (Schegloff and Lerner, 2009). Analysis of responses to *wh*-questions in everyday conversations suggests that phrasal[115] responses treat the question as unproblematic, while clausal[116] reponses indicate a responder's orientation to treat the sequence as problematic (Fox and Thompson, 2010). However, this claim cannot be confirmed with my data. The five straightforward responses I analysed show both phrasal and clausal responses, while

[115] A phrasal reponse is a phrase with a collection of words that may have nouns or verbs, but does not have a subject.

[116] A clause includes a subject (a pronoun), followed by a verb and other items linked to the verb, such as an "object", nouns phrase, a prepositional phrase, adverb or adverb phrase" (Thompson & Couper-Kuhlen, 2005, p. 484)

less-than-straightforward responses include both grammatical structures. Further work is needed to discover whether differences in findings between my analysis and Fox and Thompson's (2010) might be related to language (German vs. English), setting (mundane conversation vs. institutional interaction) or other factors.

My findings about how therapists transform patients' initial responses into goals find resonance in the recently described categorisation of 'conversational objects' (Hester and Hester, 2012). Hester and Hester (2012) argue that not only persons can be categorised (Membership Categorization Device, see Schegloff, 2007b) but also objects can be described and transformed through talk. This analytic tool can help conceptualise the transformation of goals, but the analysis must go a step further in order to be able to show that the "claim is grounded in the conduct of the parties" (Schegloff, 2007b; p. 476). In that sense, my findings regarding the transformation of goals is not an end in itself, but just the beginning of a more detailed analysis for future studies.

CA is a useful tool for highlighting practices, placing the focus not on what people think, but on what they do. Silverman (1996) observes how non-CA counselling research seeks to "develop a normative model of good counselling practices" (p. 24) assessed by either quantitative or qualitative measures. But CA can describe the practices of participants who talk social interaction into being and go "beyond guidelines and recommendations" (Hutchby, 2007; p. 134). Only by carrying out fine-grained analysis of naturally-occurring physiotherapy sessions, can we arrive at an adequate understanding of those interactional resources which come into play during the unfolding therapeutic interaction. My study provides in-depth analysis of goal setting in orthopaedic physiotherapy that has never attempted before.

A last contribution to CA is found with regard to detecting the relationship between models and theories (also called 'stocks of interactional knowledge' or SIK, Peräkylä and Vehviläinen, 2003) and actual health care interactions. These SIK related to goal setting in rehabilitation have been presented in Chapter 2 and generally can be found in professional textbooks, workbooks and training manuals. Peräkylä and

Vehviläinen (2003) argue that institutional practices cannot simply follow these described theories, concepts or models, as they are just idealised versions of practice. Rather, professionals need to "deal with a range of cases that do not reach such ideals" (Peräkylä and Vehviläinen, 2003; p. 728). My findings about how patients and physiotherapists interact during goal setting help articulate the practice of goal setting and how it is accomplished in actual practice. CA can falsify/correct assumptions hold by those concepts, or add "a new dimension to the understanding of practices" (p. 732) by providing a more detailed picture of those practices (Peräkylä and Vehviläinen, 2003). For example, in the context of opening questions in primary care Ruusuvuori (2000) was able to show that the use of open-ended (*wh*-questions) or closed questions (YNIs) is tied to the nature of the visit, i.e. if it is a first (acute) visit or a follow-up (routine) visit, rather than to whether physicians follow a 'patient-centred approach' or not. As a consequence of those findings, recommendations in text books can be adjusted by specifying the nature of the visit for the use of closed or open-ended questions. In this thesis, CA has allowed to show how goal setting – one important element of professional 'stocks of interactional knowledge' – is actually implemented, and in doing so, I have shown that some of the assumptions are insufficient when physiotherapists enquire about goals and patients responded to this question.

7.3.2 Contributions to Clinical Practice

The implications of my findings for professional practice are also multiple. My analysis reveals that examining how participants respond to the question "*what is your goal*?" opens up discussions about rights and responsibilities of knowledge that have never been attempted in physiotherapy practice before. Yet, the physiotherapy literature emphasises the patient-centred practice as an approach of partnership between patients and physiotherapists (CPO, 2009):

> "Patient-centred practice is an approach to providing physiotherapy that embraces a philosophy of respect for and partnership with people receiving services. Patient-centred practice recognizes the autonomy of individuals, the need for patient choice in making decisions about goals, the strengths patients bring to a therapy encounter, the benefits of the patient-physiotherapist

partnership, and the need to ensure that services are accessible and fit the context in which a patient lives." (CPO, 2009; p. 4).

This approach promoted here is certainly acceptable from an ethical perspective (Wirtz et al, 2006), but it does not reflect differences in knowledge between patients and physiotherapy. It also carries the assumption that the 'partnership-model' is unproblematically beneficial for physiotherapy encounters. However, the asymmetry with regard to knowledge claims which I was able to demonstrate in this thesis is not reflected upon in the physiotherapy literature.

Current goal setting policies are therefore ill fitted to the context of health care practice as they do not take into consideration concepts such as authority and entitlement which I showed are inherent to goal discussions. This non-consideration of social contingencies might also be one reason why there is inconclusive evidence as to whether goal setting has a positive impact in practice (Levack et al, 2011). My findings corroborate previous conversation analytic findings in an inpatient setting that discovered that goal setting is indeed complex, and social processes play an important role (Barnard et al, 2010). What my findings also suggest is that paying attention to the details of goal setting in practice can add new dimensions to professional 'stocks of interactional knowledge' (Peräkylä and Vehviläinen, 2003).

Extrapolating from my data, I now propose some specific practices which might better handle the epistemic contingencies I have discussed. There are of course suggestions, and their actual implementation in practice would require further empirical study. It could be suggested that explicit goal enquiries be worded differently in order to take into consideration those social processes inherent to asymmetric knowledge. A recommendation for practice, for example, could be for physiotherapists to acknowledge the difficulties for patients in formulating a goal by introducing it as follows: "*I know that it might not be easy for you coming to physiotherapy for the first time, but do you have an idea about what you would like to improve?*". Asking a question like this shows some sensitivity to epistemic issues at stake that are at play during goal enquiries.

Furthermore, it might be helpful to mutually construct a goal if therapists enquire about goals later on in the consultation as they can draw on previously exchanged information or even tentatively propose a goal in order to avoid some of the problems I showed in the most prevalent current practice.

How can this newly gained insight about goal setting be applied in clinical practice? CA has been known to work with professionals to improve their communication skills (see Section 7.5). Yet, the first step when working with healthcare professionals is to make sure that assumptions are made explicit. Another recommendation out of this study could therefore be that professionals pose questions to themselves such as "*why do I say this?*" which might help them to reflect on their own practice. It is also suggested that working with transcripts from actual interactions can make processes more transparent and assumptions explicit (Stokoe, 2011).

Overall, this study's contribution to clinical practice is foremost related to the finding that goal setting theories advocated in textbooks and articles should be adjusted to the practice of goal setting. Assumptions underlying the theories seem to be ill fitted to the social organisation of goal setting. In particular, goal setting theories should be refined by taking into consideration the asymmetry which I have shown to exist with regards to knowledge claims.

7.4. Lessons learned

7.4.1. Limitations of the study

Some limitations of the current study need noting. It was a learning process for me in terms of not only 'learning the trade' of CA, but also in terms of organising the fieldwork. The most salient limitations are associated with a) the data collection (number of consultations recorded, participants included), and relatedly b) the analysis of reaching the stated goal. Additional limitations are c) the insufficient linguistic analysis, and d) the variety of multimodal resources that remain to be explored.

Data collection

When I was planning the data collection, I based my decision about when goal setting takes place on prior experience in the field. When reviewing the literature (Bovend'Eerdt, Botell and Wade, 2009; Elzer, 2009) and policy papers (Physioswiss, 2009), goal setting is generally described as taking place in the beginning of the consultation. During my practice as a therapist, I realised that these guidelines cannot always or will not always be followed; I therefore decided to include more than just the first consultations. Yet, recording three sessions with each patient was not always sufficient in number to pin down the phenomenon under scrutiny. Physiotherapists and patients in the Swiss system know from the outset that there will be (most often) nine consultations in which they can work together. I might have discovered new aspects of goal setting by video recording all nine sessions. Related to this point is the fact that without the final consultations, it is not possible for me to examine whether goals were evaluated towards the end of physiotherapy. A detailed analysis of final consultations could also give additional insight into how goals were discussed or assessed at the end of the treatment series.

The participation for this study was voluntary and the group of physiotherapists who voluntarily signed up to take part was rather experienced. Apart from one novice and one physiotherapist with a few years of experience, many therapists were quite senior, with roles such as clinical educators or supervisors. Conclusions cannot been drawn with regard to how experience affect practices as this would require a different sampling approach.

Linguistic analysis

Before I undertook detailed analysis, I was not aware of the importance of linguistic aspects in interactions. I was surprised to learn that modal particles are indeed used as vehicles to convey social actions. Nonetheless, my knowledge was quite limited in terms of German linguistics, but even more so, in Swiss German linguistics. Unfortunately, there exist few studies related to German modal particles from an

interactional perspective (Golato and Fagyal, 2008; Barske and Betz, unpublished; Deppermann, 2011). Most German linguistic research is based on invented examples and theoretical discussions. Not much interactional research has been done on evidential markers either. While the German evidential marker *"I think"* has mainly been explored from a linguistic perspective (Schenner, 2012), evidentiality has been investigated from a sociological perspective in various languages (Kim, 2011; Nuckolls and Michael, 2012). Even though I sought studies conducted in Swiss German, they were either carried out 30 years ago (Werlen, 1985) or focused on one particle only (i.e. tag questions, Frey, 2010). Insufficient linguistic findings based on actual interactions limit the understanding of the structure and function of the Swiss German particles.

Multimodal analysis

A final point relating to limitations is the minimal exploration here of multimodal aspects of the interaction. As explained in Chapter 3, talk was considered primordial for the goal setting activity. Video-recordings provide an enormous volume of data on gestures, gaze, posture and other resources which would make a separate study. Due to time restrictions, I focused my analysis on vocal resources with a limited description of bodily aspects of the interaction (such as writing or gaze). Yet, further studies including multimodal analysis might shed light on phenomena related to social actions in physiotherapy and could yield new knowledge about physiotherapy practice.

7.5. Opportunities for future research and concluding remarks

As mentioned in Section 7.4.1 there is a need for more linguistic interactional research in German and Swiss German. A better understanding of the relationship between modal particles and social actions in the context of health care could provide the basis for cross-cultural/cross-linguistic analysis. Most of the CA work so far has examined data in English. If there were more detailed analysis on German "*jo*"-prefacing in both mundane and institutional settings, a possible comparison might be feasible. Currently, I had to draw on some concepts (*well*-prefaces) in English, but was not able to rely on sufficient interactional studies in German linguistics.

Another line of enquiry that presents itself is based on communication skills training for physiotherapists. As shown in CA research into medical interactions (Heritage and Robinson, 2011), speech and language therapy (Wilkinson, 2011) and in care situations for patients with intellectual disability (Finlay, Walton and Antaki, 2011) CA findings can be used to improve health professionals' communication skills, or as in a project with autistic children to help parents learn from professionals (Pilnick and James, 2013). In my study, I provided some feedback to staff and teams, but at an early stage of the analysis. Knowing the results now, an intervention for staff could be proposed by integrating my empirical findings into workshops fostering reflectivity. Reflective skills are an "essential characteristic for professional competence" (Mann, Gordon and McLeod, 2009; p. 595), and it is suggested that using dialogue (interaction) is a way to support successful reflection (Smith and Trede, 2011). In addition, while communication skills are taught in most health professional curricula, they rely very often on the type of goal theories I criticise in my discussion. Communication skills training would likely to be more effective if built on more detailed evidence of practice (Parry, 2008; Hulsman et al, 1999). A future study could entail interweaving teaching and learning communication skills not only in education at the university, but also during practical skills training at the work site (clinical placements). Knowing that socialisation is key to professional practice (Wenger, 1998), a future study might also investigate communicative practices in learning situations.

These limitations and future opportunities for further studies aside, it is hoped that this thesis will provide the foundation for understanding goal setting as an interactive achievement and a place where knowledge claims are negotiated. The findings indicate that contemporary theories and models of goal setting are insufficient to guide clinical practice. Goal setting is a social practice requiring attention to assumptions and epistemic dimensions. Thanks to a better comprehension of goal setting provided by an in-depth analysis of actual practice, theories can be adjusted and reformulated taking into consideration the interactive nature of the patient-physiotherapist encounter.

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Appendices

Appendix A:	Information sheet and informed consent forms for patients in private practice
Appendix B:	Information sheet and informed consent forms for professionals in hospital
Appendix C:	Flowchart for recruitment of participants
Appendix D:	Transcription Conventions
Appendix E:	Case Study B03
Appendix F:	Characteristics of participants
Appendix G:	Transcripts of all selected cases

Appendix A: Informed consent for patients

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Informationen für PatientInnen

Titel : Kommunikation in der Physiotherapie : Analyse der Interaktion zwischen PatientIn und PhysiotherapeutIn in der ambulanten Physiotherapie

Sehr geehrte Teilnehmerin, sehr geehrter Teilnehmer Lausanne, 1. Juni 2008

Allgemeine Informationen zur Studie

Das Ziel dieser Studie ist es, zu beurteilen, wie sich die Beziehung zwischen PatientInnen mit orthopädisch-rheumatologischen Problemen und den behandelnden PhysiotherpeutInnen entwickelt. Der Aspekt der verbalen und non-verbalen Kommunikation zu Beginn der Behandlung ist von grossem Interesse, da der Erfolg der Physiotherapie durch die Beziehung beeinflusst wird. Wissenschaftliche Studien konnten zeigen, dass eine gute Kommunikation positive Konsequenzen für die Patienten haben kann. Unklar ist jedoch, wie sich die Interaktion effektiv abspielt.

Ablauf der Studie

Patienten und Patientinnen mit orthopädisch-rheumatologischen Problemen (Mindestalter: 18 Jahre), die die ambulante Physiotherapie an unseren Studienorten in Anspruch nehmen, können an dieser Studie teilnehmen. Die ersten drei Physiotherapie-Sitzungen werden von der Studienleiterin gefilmt. Die Videos werden anschliessend von ihr analysiert, um die therapeutische Beziehung (Interaktion) zwischen PatientIn und PhysiotherapeutIn zu beschreiben. Die Therapiesitzungen werden in keinem Fall verändert. Die/der behandelnde TherapeutIn entscheidet zusammen mit den PatientInnen über die Planung und den Ablauf der physiotherapeutischen Behandlungen. Vorgesehen ist, 50 Patienten und Patientinnen von Juni bis Dezember 2008 in die Studie aufzunehmen.

Nutzen und Risiken

Die Nutzen sind die folgenden:

- Die Teilnahme an der Studie bringt Ihnen keinen direkten persönlichen Nutzen, hat jedoch weitergreifende Auswirkung auf die Entwicklung des Berufes und die Ausbildung.

- Eine vertiefte Einsicht über die verbale und non-verbale Kommunikation zwischen PatientIn und PhysiotherapeutIn kann zu einem verbesserten Verständnis und dadurch zu einer Verbesserung der Behandlungsqualität beitragen.

- Die Resultate dieser Studie tragen dazu bei, mehr über die therapeutische Beziehung (Interaktion) zwischen PatientIn und PhysiotherapeutIn zu erfahren und die Erkenntnisse in die Ausbildung und Weiterbildung von PhysiotherapeutInnen einfliessen zu lassen.

Die Risiken sind die folgenden:

Mit der Teilnahme an dieser Studie entstehen für Sie keine Risiken. Die Physiotherapie wird wie gewohnt von Ihrer Physiotherapeutin oder Ihrem Physiotherapeuten nach professionellen Kriterien ausgeführt.

Einschränkungen

Es gibt für Sie keine Einschränkungen, ausser der Unannehmlichkeit, dass eine dritte Person mit Filmkamera während drei Therapiesitzungen anwesend ist.

Teilnahme

Ihre Teilnahme an der Studie ist freiwillig. Wenn Sie nicht an der Studie teilnehmen möchten oder können, ergeben sich für Sie daraus keine Nachteile für Ihre weitere physiotherapeutische Betreuung. Zudem können Sie sich jederzeit von der Studie zurückziehen, ohne dass dies Konsequenzen mit sich bringt. Sie können auch nachträglich Ihre Teilnahme widerrufen. Den Rücktritt aus der Studie oder einen Widerruf der Einwilligung müssen Sie nicht begründen.

Sie können auch jederzeit während des Filmens darum anhalten, die Kamera abzustellen. Zudem haben Sie die Möglichkeit, am Ende der drei Behandlungssitzungen die Videoaufzeichnungen anzusehen und allfällige Sequenzen zu „streichen“.

Vertraulichkeit der Daten

Alle Daten, die Sie im Rahmen dieser Studie bekanntgeben, werden streng vertraulich behandelt und unterliegen der Schweigepflicht. Um einen Missbrauch der Daten zu vermeiden, wird die Hauptstudienleiterin die Daten nicht an Dritte überlassen. Die Beteiligten haben Anrecht darauf, die Videos zusammen mit der Studienleitung anzusehen, können sie jedoch nicht für sich behalten. Die Videos bleiben Eigentum der Hauptstudienleiterin. Die physische Vernichtung der Daten (Zerstören der Hard-disk, welche die Daten beinhalten) erfolgt unmittelbar nach dem letzten wissenschaftlichen Artikel, der mit Hilfe dieser Daten geschrieben wurde.

Die Formen des Datenaustausches werden in der speziellen Einverständniserklärung einzeln abgesegnet (Austausch unter ForscherInnen, Video zu Ausbildungszwecken, etc.). Für den Fall, dass die Teilnehmenden einverstanden sind, dass die Videos mit Forschern an der Universität von Nottingham (England) analysiert werden, versichert die Studienleiterin, dass die Daten beim Transport nicht aus der Hand gegeben werden. Für den Transport wird ein Speichermateriel (USB-Stick) verwendet. Es werden keine Daten elektronisch (e-mail) überwiesen. Wissenschaftliche Vorträge, die Auszüge aus Videos enthalten, werden direkt vom Speichermaterial (USB-Stick) projiziert und nicht auf den Computer heruntergeladen. Auf diese Weise wird dem Risiko vorgebeugt, dass die Videos über Internet an die Öffentlichkeit geraten.

Kontaktpersonen

Bei Fragen und Problemen, die im Rahmen dieser Studie auftreten, wenden Sie sich bitte an:

(Name of Private Practice Owner deleted)

oder an die Hauptstudienleiterin:

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Wir danken Ihnen für das Lesen dieser Information

Schriftliche Einverständniserklärung der PatientInnen zur Teilnahme an einer klinischen Studie

Titel : **Kommunikation in der Physiotherapie : Analyse der Interaktion zwischen PatientIn und PhysiotherapeutIn in der ambulanten Physiotherapie**

Institution : ……. No. ID :…….

Bitte lesen Sie dieses Formular sorgfältig durch.

Bitte fragen Sie, wenn Sie etwas nicht verstehen oder zusätzlich wissen möchten.

Ich bin mit den folgenden Punkten einverstanden:

- Ich wurde von der Studienleitung mündlich und schriftlich über die Ziele, den Ablauf der Studie, sowie über den möglichen Nutzen bzw. die Risiken informiert.

- Ich habe die zur Studie abgegebene schriftliche Information („Informationen für PatientInnen“, datiert 1. Juni 2008) gelesen und verstanden. Meine Fragen im Zusammenhang mit der Teilnahme an der Studie sind mir zufriedenstellend beantwortet worden. Ich kann die schriftliche Patientinneninformation und das Doppel der Einverständniserklärung behalten.

- Ich hatte genügend Zeit, um meine Entscheidung zu treffen.

- Ich nehme an dieser Studie freiwillig teil. Ich kann jederzeit ohne Angabe von Gründen meine Zustimmung zur Teilnahme widerrufen, ohne dass mir deswegen Nachteile bei der weiteren physiotherapeutischen Betreuung entstehen.

Wenn Sie gerne an dieser Studie mitmachen möchten, unterschreiben Sie bitte diese Form. Wenn Sie gerne anonym bleiben möchten, werden die Videoaufnahmen nur von der Hauptstudienleiterin Frau V. Schoeb analysiert.

Name, Vorname des Patienten/der Patientin:

Unterschrift : Ort/Datum :

Unterschrift der Studienleitung:

Wenn Sie damit einverstanden sind, dass Auszüge von Videoaufnahmen oder Transkriptionen (Niederschrift der Gespräche) für weitere Zwecke (wissenschaftliche Vorträge und Artikel oder zu Ausbildungszwecken) verwendet werden dürfen, lesen Sie bitte auf der nächsten Seite weiter.

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   Initialen :_____

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   Initialen :_____

3. Die **Transkriptionen (Niederschrift der Gespräche)** dürfen für Lehrzwecke (Ausbildung oder Weiterbildung) verwendet werden.

   Initialen :_____

4. Auszüge von **Videoaufnahmen** dürfen für wissenschaftliche Vorträge verwendet werden.

   Initialen :_____

5. Die **Transkriptionen (Niederschrift der Gespräche)** dürfen für wissenschaftliche Vorträge verwendet werden.

   Initialen :_____

6. Die **Transkriptionen (Niederschrift der Gespräche) oder Videostandbilder** dürfen für wissenschaftliche Artikel verwendet werden.

   Initialen :_____

Ich habe die obengenannten Möglichkeiten der Videoaufnahmen und Transkriptionen (Niederschrift der Gespräche) gelesen und gebe mit meinen Initialen meine Zusage.

Appendix B: Informed consent for professionals

Logo deleted

Informationen für teilnehmende PhysiotherapeutInnen

Titel : Kommunikation in der Physiotherapie : Analyse der Interaktion zwischen PatientIn und PhysiotherapeutIn in der ambulanten Physiotherapie

Sehr geehrte Teilnehmerin, sehr geehrter Teilnehmer Lausanne, 1. Juni 2008

Allgemeine Informationen zur Studie

Das Ziel dieser Studie ist es, zu beurteilen, wie sich die Beziehung zwischen PatientInnen mit orthopädisch-rheumatologischen Problemen und den behandelnden PhysiotherpeutInnen entwickelt. Der Aspekt der verbalen und non-verbalen Kommunikation zu Beginn der Behandlung ist von grossem Interesse, da der Erfolg der Physiotherapie durch die Beziehung beeinflusst wird. Wissenschaftliche Studien konnten zeigen, dass eine gute Kommunikation positive Konsequenzen für die Patienten haben kann. Unklar ist jedoch, wie sich die therapeutische Beziehung (Interaktion) effektiv abspielt.

Ablauf der Studie

Patienten und Patientinnen mit orthopädisch-rheumatologischen Problemen (Mindestalter: 18 Jahre), die die ambulante Physiotherapie an unseren Studienorten in Anspruch nehmen, können an dieser Studie teilnehmen. Die ersten drei Physiotherapie-Sitzungen werden von der Studienleiterin gefilmt. Die Videos werden anschliessend von ihr analysiert, um die therapeutische Beziehung (Interaktion) zwischen PatientIn und PhysiotherapeutIn zu beschreiben. Die Therapiesitzungen werden in keinem Fall verändert. Sie entscheiden zusammen mit dem Patienten oder der Patientin über die Planung und den Ablauf der physiotherapeutischen Behandlungen. Vorgesehen ist, 50 Patienten und Patientinnen von Juni bis Dezember 2008 in die Studie aufzunehmen.

Nutzen und Risiken

Die Nutzen sind die folgenden:

- Die Teilnahme an der Studie bringt Ihnen keinen direkten persönlichen Nutzen, hat jedoch weitergreifende Auswirkung auf die Entwicklung des Berufes und die Ausbildung.

- Eine vertiefte Einsicht über die verbale und non-verbale Kommunikation zwischen PatientIn und PhysiotherapeutIn kann zu einem verbesserten Verständnis und dadurch zu einer Verbesserung der Behandlungsqualität beitragen.

- Die Resultate dieser Studie tragen dazu bei, mehr über die therapeutische Beziehung (Interaktion) zwischen PatientIn und PhysiotherapeutIn zu erfahren und die Erkenntnisse in die Ausbildung und Weiterbildung von PhysiotherapeutInnen einfliessen zu lassen.

Die Risiken sind die folgenden:

Mit der Teilnahme an dieser Studie entstehen für Sie keine Risiken. Sie führen die geplante Physiotherapie nach Ihren professionellen Kriterien aus.

Einschränkungen

Es gibt keine Einschränkungen, ausser der Unannehmlichkeit, dass eine dritte Person mit Filmkamera während drei Therapiesitzungen anwesend ist.

Teilnahme

Ihre Teilnahme an der Studie ist freiwillig und für Sie ohne Nachteile. Zudem können Sie sich jederzeit von der Studie zurückziehen. Sie können auch nachträglich Ihre Teilnahme widerrufen. Den Rücktritt aus der Studie oder einen Widerruf der Einwilligung müssen Sie nicht begründen.

Sie können auch jederzeit während des Filmens darum anhalten, die Kamera abzustellen. Zudem haben Sie die Möglichkeit, am Ende der drei Behandlungssitzungen die Videoaufzeichnungen anzusehen und allfällige Sequenzen zu „streichen".

Vertraulichkeit der Daten

Alle Daten, die Sie im Rahmen dieser Studie bekanntgeben, werden streng vertraulich behandelt und unterliegen der Schweigepflicht. Um einen Missbrauch der Daten zu vermeiden, wird die Hauptstudienleiterin die Daten nicht an Dritte überlassen. Die Beteiligten haben Anrecht darauf, die Videos zusammen mit der Studienleitung anzusehen, können sie jedoch nicht für sich behalten. Die Videos bleiben Eigentum der Hauptstudienleiterin. Die physische Vernichtung der Daten (Zerstören der Hard-disk, welche die Daten beinhalten) erfolgt unmittelbar nach dem letzten wissenschaftlichen Artikel, der mit Hilfe dieser Daten geschrieben wurde.

Die Formen des Datenaustausches werden in der speziellen Einverständniserklärung einzeln abgesegnet (Austausch unter ForscherInnen, Video zu Ausbildungszwecken, etc.). Für den Fall, dass die Teilnehmenden einverstanden sind, dass die Videos mit Forschern an der Universität von Nottingham (England) analysiert werden, versichert die Studienleiterin, dass die Daten beim Transport nicht aus der Hand gegeben werden. Für den Transport wird ein Speichermateriel (USB-Stick) verwendet. Es werden keine Daten elektronisch (e-mail) überwiesen. Wissenschaftliche Vorträge, die Auszüge aus Videos enthalten, werden direkt vom Speichermaterial (USB-Stick) projiziert und nicht auf den Computer heruntergeladen. Auf diese Weise wird dem Risiko vorgebeugt, dass die Videos über Internet an die Öffentlichkeit geraten.

Kontaktpersonen

Bei Fragen und Problemen, die im Rahmen dieser Studie auftreten, wenden Sie sich bitte an die Studienleiterin des Kantons Solothurn:

(Name of Director of Physiotherapy Department deleted)

oder an die Hauptstudienleiterin:

Veronika Schoeb, Physiotherapeutin OMT, MHA, cand. PhD

Haute Ecole Vaudoise de la Santé, HECVSanté

21, ave de Beaumont , 1011 Lausanne

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Wir danken Ihnen für das Lesen dieser Information

Schriftliche Einverständiserklärung der PhysiotherapeutInnen zur Teilnahme an einer klinischen Studie

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   Initialen :_____

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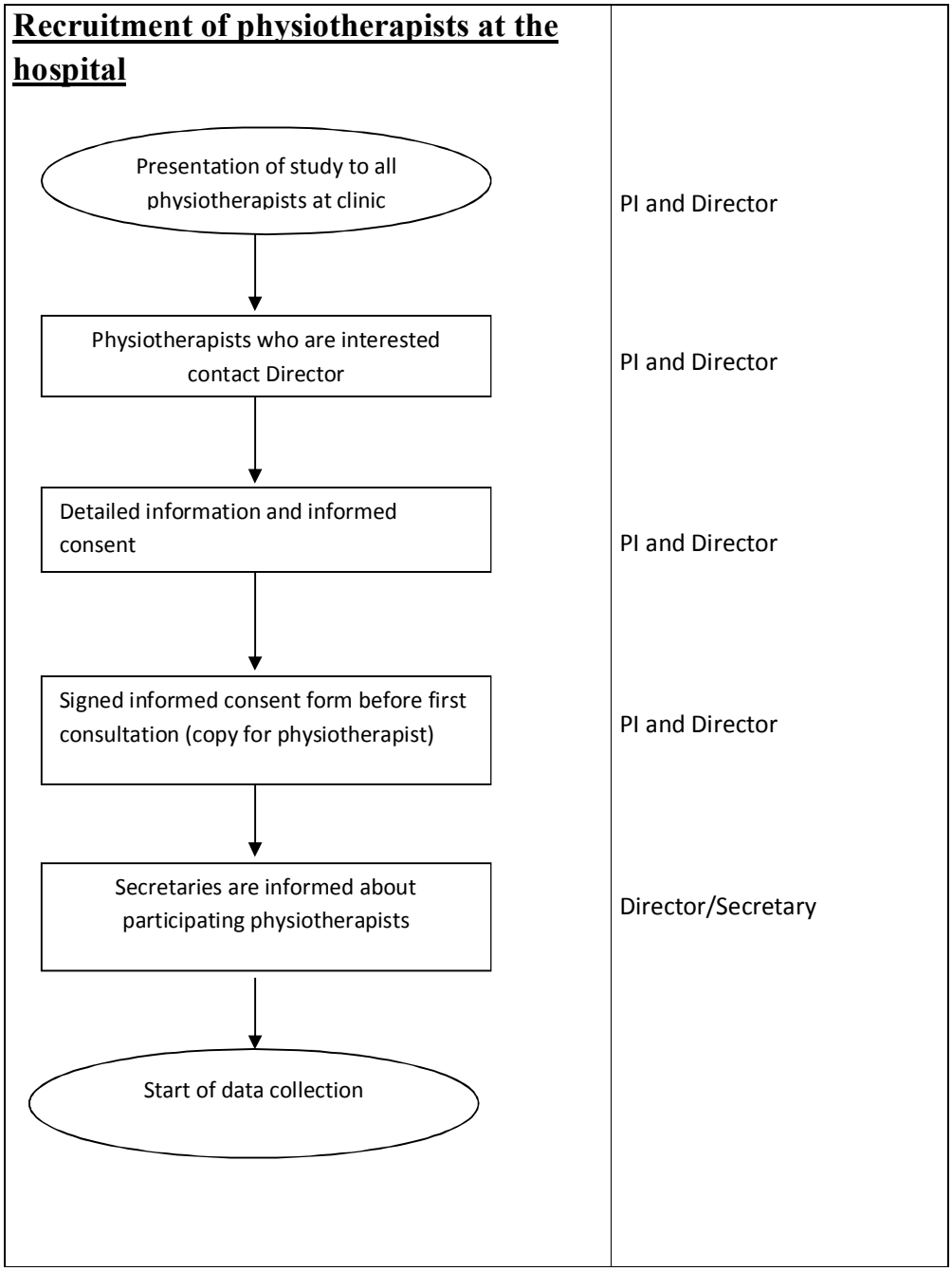
   Initialen :_____

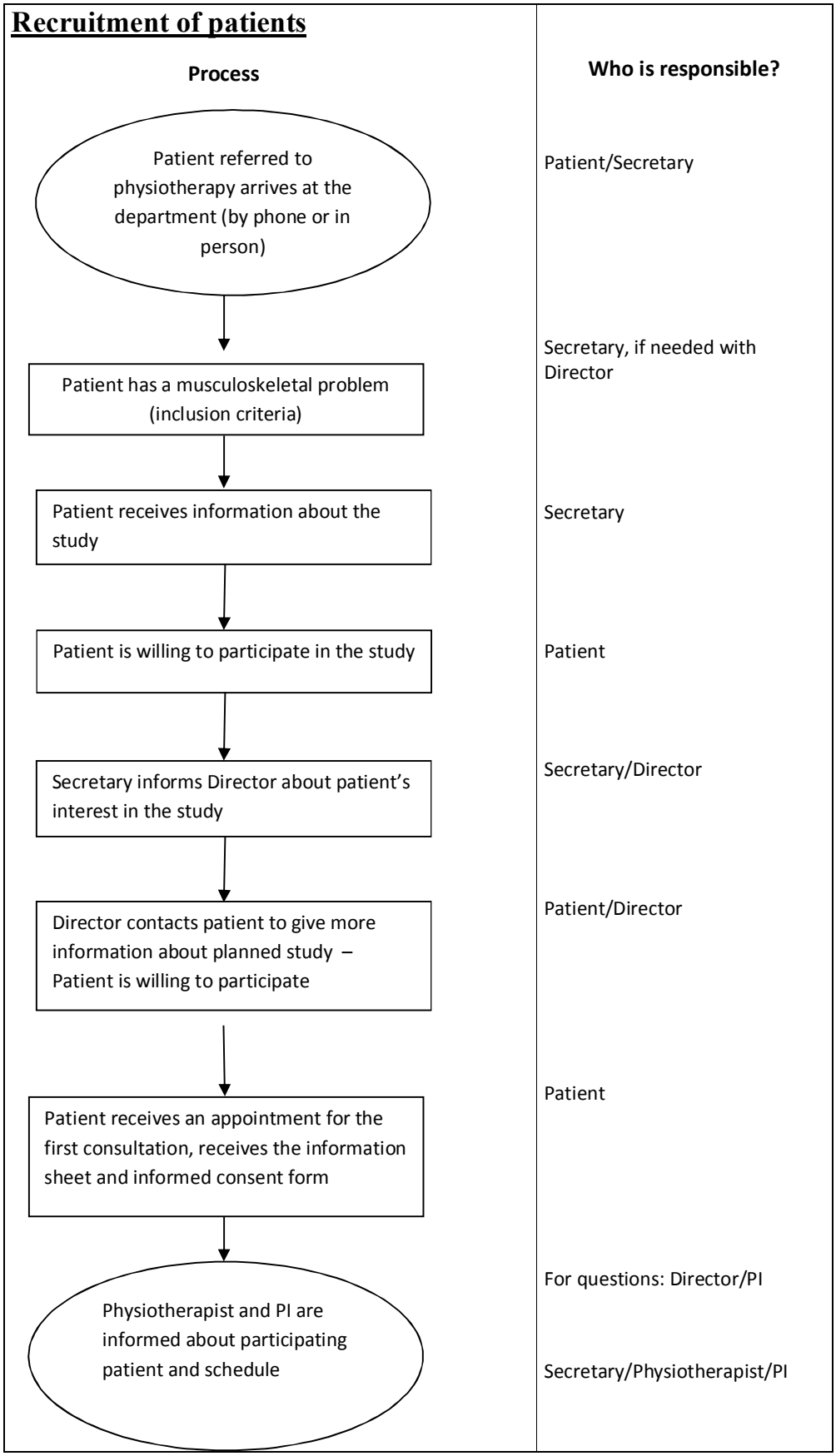
Ich habe die obengenannten Möglichkeiten der Videoaufnahmen und Transkriptionen (Niederschrift der Gespräche) gelesen und gebe mit meinen Initialen meine Zusage.

Appendix C: Flowchart for recruitment

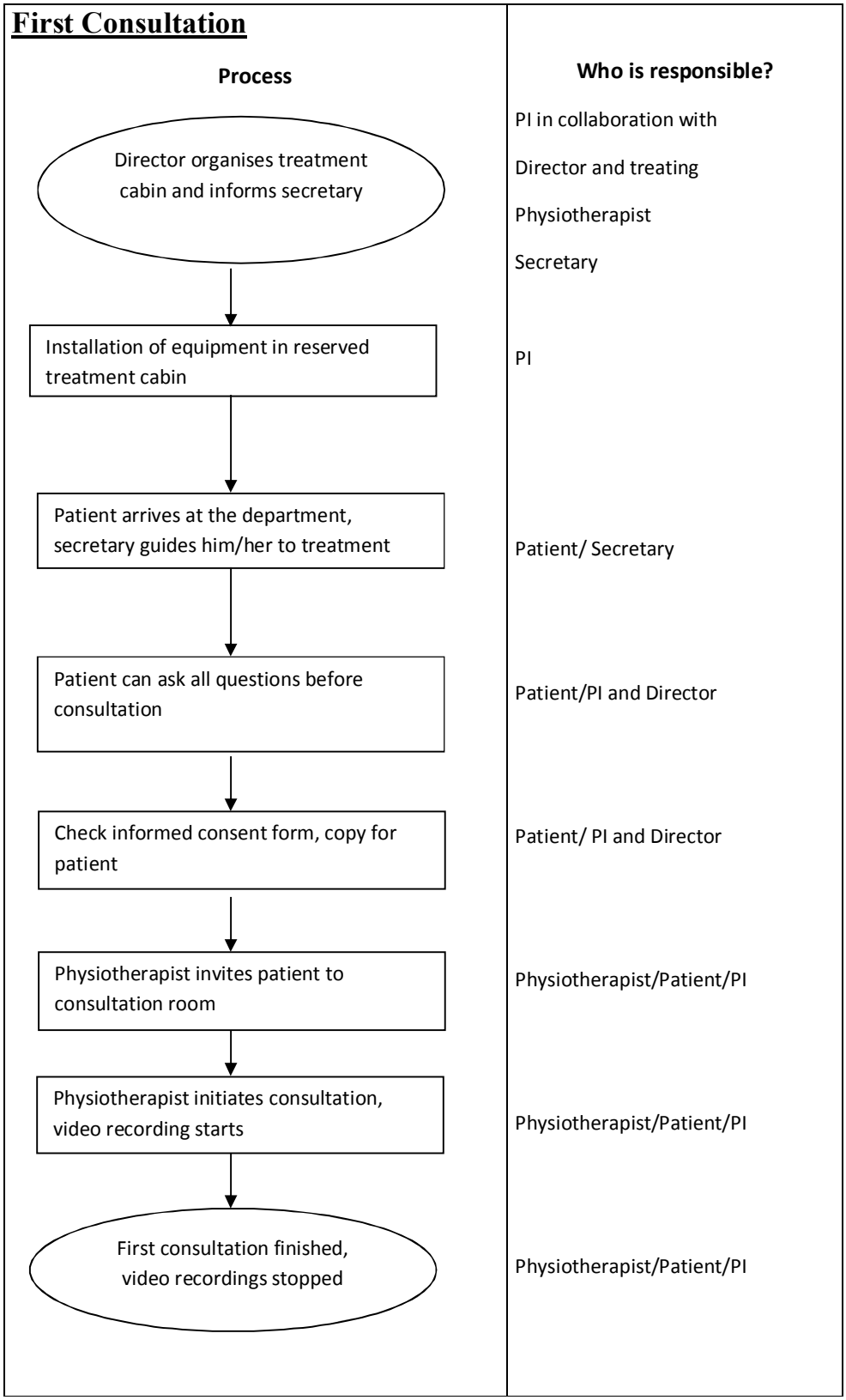
Flowchart for recruitment and treatment during the study "Communication in Physiotherapy"



Appendix C: Flowchart of participants' recruitment - Hospital



Appendix C: Flowchart of participants' recruitment - Hospital



For the second and third consultations, the consent will be confirmed orally both with patients and therapists. Otherwise, the process is similar to the one in the first consultation.

Appendix D: Transcription Conventions

(Jefferson, 2004)

Symbols	Explanation
[ ]	Indicates the point where overlap begins and ends
(0.0)	Indicates elapsed time in silence in tenths of a second either within or between utterances
(.)	Indicates a gap of less than 0.1 second
↑↓	Indicates marked shifts into higher or lower pitch in the utterance immediately following the arrow
-	Horizontal dash indicates that the word sounds abruptly ñcut offò
°	Indicates quieter passage of talk compared to the surrounding talk
Word	Indicates some form of stress, via pitch and/or amplitude
::	Indicates an extension of the syllable it follows
=	Indicates that there is no interval between two utterances
,	Indicates a continuing indication, as when someone is reading items from a list
.	Indicates a stopping fall in tone
?	Indicates a rising intonation
WORD	Indicates especially loud sounds relative to the surrounding talk
.hhh	Indicates an inbreath, without a dot an outbreath
w(hhh)ord	Indicates breathiness, as in laughter, crying, etc.
< >	Indicates slowing down
> <	Indicates speeding-up
( ) **(word)**	Indicates that the transcriptionist is not able to hear the utterance
(( ))	Indicates a description of a phenomenon (e.g. laughter, noiseé)

Appendix E: Case study

Case study B03

Patient: female, St. post discectomy-surgery L5/S1 (8 May 2008), concierge of a school (40%)

Physiotherapist: female, 40 years old, 17 years of experience, group leader, works in institution since 1996

Treatment: Rx1 (8 July 2008); Rx2 (10 July 2008); Rx3 (15 July 2008) ï 30 minutes each

Goal setting in Rx1

At **3.36** the physiotherapist is asking about hobbies, which gives the patient an opportunity to introduce her goals (minigolf). The therapist continues to give the patient an opportunity to take the floor, but only after a follow up question by the physiotherapist (ñ*anything else?*ò) the patient volunteers more activities (knitting) while presenting doubts about its appropriateness.

At **4.23** the therapist introduces the history taking with the question ñ*at the moment what is the main problem for you?*ò The patient already proposes the diagnosis and treatment options (muscle training, sacro-iliac joint blocked), entering the symptom description (pain radiating into buttocks, tingling) with an assessment of gravity (but not too bad, supposedly stays for a while), as well as explaining an activity (taking big steps) related to the aggravation of symptoms (jabbing) followed by an assessment and laughter (but this is normal I would say).

At **21.14** the physiotherapist introduces the topic of treatment goals by referring to what has been discussed before. The patient is making reference to what the doctor prescribed for her (training for trunk muscles). The therapist is sustaining her gaze from the middle of the sequence acknowledging the patientôs information.

At **22.34** the physiotherapist introduces again the topic of goal setting by saying that the muscle training is what is prescribed by the doctor (quite a bit of gesticulation, movement). The question for the patient is asked: ñyour goal or your expectation?ò The patient does not talk for 2.0 seconds, the therapist continues to look at patient until the patient continues: ñ*well, it is simply (.).....*ò.
This sequence is then followed by what two or three activities the patient would like to improve, e.g. minigolf (other way of saying what goals? ï related to Patient-specific Functional Scale (PSFS) questionnaire, an outcome measure used at the hospital), followed by an assessment of the ñbadò position that the therapist does not take up. She is more interested in other activities (ñ*you talked about lifting desks" – would that be something else that you would like to improve?*). The patient provides a second activity (using the vacuum cleaner) and the physiotherapist follows up to find possibly a third activity, but the patient does not add more than two activities.

Appendix F: Participants' Characteristics

Patient	Place	Date	Time	Diagnosis	Patient Code	Physio Code	Code
Pilot test	Hospital	28.5.2008	9h30 - 10h15	Osteosynthesis after fracture of tibia	B01	PTa	B01 PTa Rx1
1	Hospital	3.7.2008	15h30 - 16h15	Hip arthroplasty	B02	PTb	B02 PTb Rx1
		8.7.2008	11h - 11h30				B02 PTb Rx2
		10.7.2008	10h - 10h35				B02 PTb Rx3
2	Hospital	8.7.2008	10h - 10h35	Post-surgical herniated disc L5/S1 (8.5.2008)	B03	PTc	B03 PTc Rx1
		10.7.2008	16h15 - 16h50				B03 PTc Rx2
		15.7.2008	9h05 - 9h35				B03 PTc Rx3
3	Hospital	8.7.2008	16h30 - 17h	Right knee pain	B04	PTd	B04 PTd Rx1
		10.7.2008	17h - 17h30				B04 PTd Rx2
		17.7.2008	10h - 10h25				B04 PTd Rx3
4	Hospital	15.7.2008	11h35 - 12h05	Back pain	B05	PTe	B05 PTe Rx1
		17.7.2008	14h05 - 14h30				B05 PTe Rx2
		22.7.2008	11h30 - 12h				B05 PTe Rx3

Appendix F: Participants' Characteristics

5	Hospital	15.7.2008	13h - 13h35	Tinnitus	B06	PTf	B06 PTf Rx1
		17.7.2008	13h - 13h35				B06 PTf Rx2
		24.7.2008	12h50 - 13h20				B06 PTf Rx3
6	Hospital	15.7.2008	14h05 - 14h35	Muscle strain left M. Iliopsoas	B07	PTe	B07 PTe Rx1
		17.7.2008	11h - 11h30				B07 PTe Rx2
		22.7.2008	14h - 14h35				B07 PTe Rx3
7	Hospital	15.7.2008	15h - 15h35	Fracture of left humerus	B08	PTd	B08 PTd Rx1
		17.7.2008	9h - 9h30				B08 PTd Rx2
		22.7.2008	9h - 9h30				B08 PTd Rx3
8	Hospital	17.7.2008	11h30 - 12h	Post-surgical arthroscopy of left shoulder	B09	PTe	B09 PTe Rx1
		22.7.2008	10h30 - 11h				B09 PTe Rx2
		24.7.2008	12h - 12h25				B09 PTe Rx3
9	Hospital	17.7.2008	14h45 - 15h30	Whiplash injury (1.5.2008)	B10	PTg	B10 PTg Rx1
		24.7.2008	14h05 - 14h35				B10 PTg Rx2
		31.7.2008	13h - 13h35				B10 PTg Rx3

Appendix F: Participants' Characteristics

10	Hospital	22.7.2008	9h35 - 10h15	Lumbar radiculopathy	B11	PTd	B11 PTd Rx1
		24.7.2008	13h30 - 14h05				B11 PTd Rx2
		28.7.2008	9h35 - 10h				B11 PTd Rx3
11	Hospital	24.7.2008	9h30 - 10h10	Knee pain	B12	PTg	B12 PTg Rx1
		28.7.2008	13h30 - 14h05				B12 PTg Rx2
		31.7.2008	11h30 - 12h				B12 PTg Rx3
12	Hospital	24.7.2008	14h40 - 15h25	Failed back syndrome	B13	PTg	B13 PTg Rx1
		4.8.2008	9h05 - 9h30				B13 PTg Rx2
		7.8.2008	14h40 - 15h10				B13 PTg Rx3
13	Hospital	28.7.2008	11h05 - 11h50	Post-surgical herniated disc L5/S1 left (17.7.2008)	B14	PTg	B14 PTg Rx1
		4.8.2008	9h35 - 10h15				B14 PTg Rx2
		7.8.2008	14h05 - 14h35				B14 PTg Rx3
14	Hospital	28.7.2008	16h10 - 16h40	Shoulder weakness / partial nerve lesion	B15	PTg	B15 PTg Rx1
		4.8.2008	13h - 13h30				B15 PTg Rx2
		7.8.2008	11h30 - 12h				B15 PTg Rx3

Appendix F: Participants' Characteristics

15	Hospital	28.7.2008	16h45 - 17h10	Low back pain	B16	PTe	B16 PTe Rx1
		31.7.2008	14h30 - 15h				B16 PTe Rx2
		4.8.2008	8h30 - 9h				B16 PTe Rx3
16	Hospital	31.7.2008	8h45 - 9h20	Left knee pain	B17	PTb	B17 PTb Rx1
		4.8.2008	13h30 - 14h				B17 PTb Rx2
		12.8.2008	11h - 11h30				B17 PTb Rx3
17	Hospital	31.7.2008	10h30 - 11h15	Low back pain	B18	PTb	B18 PTb Rx1
		4.8.2008	10h35 - 11h05				B18 PTb Rx2
		7.8.2008	10h30 - 11h05				B18 PTb Rx3
18	Hospital	31.7.2008	12h - 12h35	Hip arthritis	B19	PTb	B19 PTb Rx1
		4.8.2008	11h30 - 12h				B19 PTb Rx2
		7.8.2008	12h - 12h30				B19 PTb Rx3
19	Hospital	25.11.2008	10h30 - 11h	Low back pain	B20	PTc	B20 PTc Rx1
		27.11.2008	10h30 - 11h05				B20 PTc Rx2
		4.12.2008	10h30 - 11h				B20 PTc Rx3

Appendix F: Participants' Characteristics

20	Private Practice	13.1.2009	9h05 - 9h50	Asthma	G01	PTk	G01 PTk Rx1
		15.1.2009	9h05 - 9h35				G01 PTk Rx2
		22.1.2009	10h05 - 10h30				G01 PTk Rx3
21	Private Practice	15.1.2009	11h - 11h30	Post-fracture of left clavicula	G02	PTn	G02 PTn Rx1
22	Private Practice	13.1.2009	11h05 - 11h50	Shoulder pain and headache	G03	PTm	G03 PTm Rx1
		20.1.2009	10h40 - 11h35				G03 PTm Rx2
		22.1.2009	11h10 - 11h50				G03 PTm Rx3
23	Private Practice	15.1.2009	10h05 - 10h45	Low back pain	G04	PTl	G04 PTl Rx1
		20.1.2009	9h30 - 9h50				G04 PTl Rx2
		27.1.2009	10h05 - 10h30				G04 PTl Rx3
24	Private Practice	20.1.2009	8h35 - 9h15	Osteosynthesis after tibial fracture right	G05	PTk	G05 PTk Rx1
		22.1.2009	10h35 - 11h05				G05 PTk Rx2
		27.1.2009	9h10 - 9h40				G05 PTk Rx3
25	Private Practice	23.1.2009	10h05 - 10h45	Hip arthroplasty	G06	PTn	G06 PTn Rx1
		29.1.2009	15h10 - 15h45				G06 PTn Rx2
		3.2.2009	11h05 - 11h30				G06 PTn Rx3

Appendix F: Participants' Characteristics

26	Private Practice	27.1.2009	11h40 - 12h15	Lesion of M. supraspinatus	G07	PTm	G07 PTm Rx1
		29.1.2009	11h10 - 11h35				G07 PTm Rx2
		3.2.2009	9h05 - 9h50				G07 PTm Rx3
27	Private Practice	29.1.2009	10h05 - 10h45	Tennis elbow	G08	PTl	G08 PTl Rx1
		3.2.2009	10h05 - 10h35				G08 PTl Rx2
		10.2.2009	10h05 - 10h35				G08 PTl Rx3

Appendix G: Transcripts

B03 PTc Rx1_22.34

1 Physio Aso eues Ziel oder eui Erwartig ad Physiotherapie (.)

So your goal or your expectation for the physiotherapy (.)

So your goal or your expectation for physiotherapy (.)

2 >dir heit gseit de Chraftufbau das isch der Uftrag vum ↑Arzt<

>you had said the force improvement this is the demand from the ↑physician<

>you said that the physician would like to have the strength improved<

3 (0.5)

4 Physio E::::hm

U::::hm

5 (1.6)

6 Physio Eues Ziel oder eui Erwartig

Y**our goal or your expectation**

7 (1.7)

8 Patient ↓Jo isch eifacht (.) dass i im Prinzip weiss (.) was i de au selber cha ↑mache [oder]

↓PART is MOD (.) that I in principle know (.) what I then also myself can ↑do [can't I]

***Jo* it is *eifacht* that I know in principle what I can do by myself as well can't I?**

9 Physio **[↑Mhm]**

10 (0.7)

11 Patient Ebe was ich vielicht au wett dass- eh (.) dass- eh dass der mir irgendwie d'Grät=

PART what I probably also would like that- eh (.) that- eh that you me somehow the equipment=

***Ebe* what I probably would like as well is that- eh (.) that- eh that you would show**

12 =würded ↑zeige [wo] de mol guet [wäred] ou (.) dass wenni de mol-

=would ↑show [that] then PART good [would be] as well (.) that when I then PART-

me somehow the equipment that would be *mol* good later on as well (.) that when I then *mol*-

13 Physio **[Mhm]** **[↑Mhm]**

14 Patient in Gluren heimmer jo au sone (.) Physio eh- mit eh- Fitnessstudio

in Gluren we have PART also such a (.) physio eh- with a fitness studio

in Gluren we have *jo* as well such a physio eh- with a- fitness studio

15 Physio **↑Mh[m]**

16 Patient [dass] wenni dörrt go dass i eigentli:ch (.)

[that] when I there go that I actuall:y (.)

that in case I go there I would actually know

17 wüsst was i z'tue ↑hä [säg ich's emol] so

would know what I to do ↑would have [say I it once] like this

what I had to do let's put it that way

18 Physio **[↑Mhm]**

19 (0.6)

20 Physio **Mhm.**

B04 PTd Rx1_6.58

1 Physio E::hm (.) was machsch Du brueflich?

E::hm (.) what make you professionally?

E::hm (.) what do you do professionally?

2 (0.2)

3 Patient I bi diplomierti Pflegfachfra(h)u(h) [d(h)o o(h)be] hehehe

I am diplomed nurse professio(h)na(h)l [he(h)re u(h)p]hehehe

I am a registered nurse up th(h)ere hehehe

4 Physio **[hehehe]**

5 (2.0) *((PT is writing in her chart))*

6 Physio **Mhm**

7 (0.5) *((PT is writing in her chart))*

8 Physio .hh Wieviel Prozent de.

.hh How many percent then.

.hh What is the percentage of employment then.

9 Patient Achzig

Eighty

Eighty percent

10 (7.3) ***((****Physiotherapist writes in chart))*

11 Physio **tss**

12 (0.4) ***((****Physiotherapist stops writing but continues to look at her chart))*

13 E:::::hm (.) J:a und was isch dis Ziel?

U::::hm (.) Ye:s and what is your goal?

14 (0.5) ***((****Physiotherapist looks at patient))*

15 Patient Mis Ziel isch dass ich wieder cha go jogge so wienich körperlich au ↑mag

My goal is that I again can go to jog like the way I physically also ↑be able

My goal is that I can go running again as much as I am physically able to

16 Physio **↑Mh[m]** ***((****Physiotherapist writes in chart))*

17 Patient [o]hni dass mi de Schmerz behinderet

[wi]thout that me the pain handicapped

without being bothered by the pain

18 (2.1) ***((****Physiotherapist continues to write in her chart))*

19 Patient Eifacht dass ich die Sportarte wonich gern mache eifach wieder cha usfüehre=

MOD that I the types of sports that I like to do MOD again can execute=

Eifacht **that I can** ***eifacht*** **do the sports again that I like to do and that I can**

20 =und mi frei (.) cha füehle und-

=and myself free (.) can feel and-

feel myself ready and-

21 (0.5)

22 Patient [Jo]

[Yes]

23 Physio **[Mhm.]** *((Physiotherapist looks at patient))*

24 (1.1)

25 Physio Machsch no anderi Sportarte i dem Fall oder?

Do you do still other types of sport in that case huh?

In that case do you do other sports as well huh?

26 Patient .hh jo aso eigentlich ↑Velofa:hre aber eifach meh so dr- d'Wägschtrecki [ned eh-]

hh yes so actually ↑biki:ng but MOD more so th- the path distance [not eh-]

hh yes so actually biking but ***eifach*** **more so th- the path not eh-**

27 Physio **[Mhm]**

28 Patient ned Rennvelo sondern normal ↑Velofahre (.) und ehm (.)

not racing bike but normal ↑biking (.) and uhm (.)

not racing bike but normal biking and uhm

29 bim Viva jo das isch so Gymnastik Kreislauf-ehm Training

at the Viva PART that is so gymnastics cardio- uhm training

at the Viva ***jo*** **this is a kind of gymnastics cardio- ehm training**

30 Physio **Mhm**

31 Patient für Fraue (0.5) eh:m jo das sind eigentlich die Arte

for women (0.5) uh:m PART those are actually the types

for women (0.5) uh:m ***jo*** **these are actually the types (of sports)**

32 (0.4)

33 Physio **↑Mhm**

34 (1.7)

35 Physio Gu:et

Go:od

36 (1.3)

37 Physio Jetze de Schmerz do im Chnäu so vum Morge bis am Abe het da irgendwie- (.)

Now the pain here in the knee so from the morning until the evening is here anyhow (.)

Now with the pain here in the knee from the morning until the evening is there somehow

38 het de irgend en Zämehang mit de Tageszit od[er-]

has it any connection with the time of the day o[r-]

is there any relationship with the time of the the day or-

39 Patient [Ne]i isch würklich nach- [nach]=

[No] is really after- [after]=

No it is really only after- after

40 Physio [Eifach-]

[MOD]

Eifach-

41 Patient =de sportliche Betäti[gung]

=the sportive activi[ty]

the sports activities

42 Physio **[Mhm]**

43 (0.6)

44 Patient Das het mi dem z'tue

This has with this to do

It has to do with that

B06 PTf Rx1_16.06

1 Physio .hh jetzt (.) was heit Ihr für ve- für Vorstellige oder Erwartige jetzt ad Therapie?

.hh now (.) what have you for ima- for imaginations or expectations now for therapy?

.hh what kind of ima- of imaginations or expectations do you have now for therapy?

2 heit ihr scho mol eh- Therapie ↑gmacht für Euchi Beschwerde woder heit

have you already once eh- therapy ↑made for your problems that you have

have you previously had therapy for your current problems

3 Massage heiter vorher gseit

massage have you before said

you have talked about massage before

4 (0.6)

5 Patient Ja:a gangi eifacht einisch im Monet [(.) g]a massiere

Ye:es go I MOD once a month [(.) t]o do massage

Yes I *eifacht* go once a month to get a massage

6 Physio [Ja]

[Yes]

7 (1.2)

8 Physio Das macheder scho ↑länger [oder jet]zt uf Grund v[um-] (.) vu de Beschwerde

This do you already ↑longer [or no]w as the cause o[f] (.) of the problems

Have you been doing this for a long time already or now because of your problems

9 Patient [Ja] [Mhm]

[Yes] **[Mhm]**

10 Patient Unabhängig [ja so-]

Independent [yes so-]

11 Physio [Das gö]nneder Euch eifacht einisch im Monet ↑schö[n.] Ja [hehehe]

[This tre]at you yourself MOD once a month ↑nic[e.] Yes [hehehe]

This is a treat for you *eifacht* once a month nice. Yes [hehehe]

12 Patient [Genau] [Ja hehehe]

[Exactly] [Yes hehehe]

13 (0.2)

14 Physio Guet

Good

15 (1.0)

16 Physio Anderi Therapie?

Other therapies?

17 (3.1)

18 Patient Aso-

PART-

19 (1.5)

20 Patient aber vor- vor Jahre bini scho einisch ine Physiotherapie wegem (.)

but before- before years am I already once in a physiotherapy because of the (.)

but years ago I went once to physiotherapy because of the neck

21 Äcke will ich da eifach so (.) stief bi gsi

neck because I there MOD so (.) stiff have been

because I was *eifach* so stiff there

22 (0.3)

23 Physio **Mhm**

24 (0.4)

25 Physio **Mhm**

26 (3.1)

27 Physio Und das isch de wieder weg gange.

And this is then again away gone.

And this went again away.

28 (0.4)

29 Patient [Ja es isch de när besser gange]

[Yes it is then afterwards better gone]

Yes afterwards it was better again

30 Physio [Dür d'Therapie]

[Through the therapy]

Thanks to therapy

31 (0.8)

32 Physio Ja

Yes

33 (1.4)

34 Patient Sie het mir au eh- denn (.) Üebige (.) mitgeh für selber z'mache .h

She has me also uh- then (.) exercises (.) given for myself to do .h

She also gave me uh- then some exercises to do by myself .h

35 aso ich han eifacht gmerkt bi mir isch- (0.7) mit z'viel Üebige deheime mache das haut de ned

so I have MOD realised with me is- (0.7) with too many exercises at home do this works then not

So I *eifacht* realised that for me it- (0.7) it does not work to do too many exercises at home

36 Physio **Mhm mhm**

37 (0.7)

38 Physio Au[so-]

S[o-]

39 Patient [Das] isch denn sochli- (.)

[This] is then a bit- (.)

40 Patient **[( ) h e h e h e h e h e]**

41 Physio [De chiememer nomol zu de Erwartige wonich Euch vorher unterbroche ↑ha]

[Then came we once again to the expectations that I you before interrupted ↑have]

Let's come back to the expectations that I interrupted you before

42 was heiter für Erwartige ad Therapie

what have you for expectations for therapy

what expectations do you have for therapy

43 (1.8)

44 Patient Aso wen:n's öppis isch woni deheime (.) sött mache de nächär-

So if:f it something is that I at home (.) should do then afterwards-

So if it is something I should be doing at home afterwards-

45 (1.8)

46 >sötts eifacht öppis si wome ned z'lang-< (.) wome-

>should it MOD something be that one not too long- < (.) that one-

it should *eifacht* be something that does not take too long- that one-

47 (1.8)

48 scho:o jede Tag aber eifacht- aber nid- eh (.) nid z'lang.

already every day but MOD- but not- eh (.) not too long.

still every day but *eifacht*- but not- eh (.) not for too long.

49 [(.) n]id ewigs muess turne (.) will mer nächer eifacht die Ziet ned ↑nimme

[(.) n]ot eternally must exercise (.) because me afterwards MOD the time not ↑take

not have to exercise eternally (.) because I *eifacht* do not take the time afterwards

50 Physio **[Mhm]**

51 (4.5)

52 Physio **Mhm**

53 (0.6)

54 Physio Aber jede Tag chönnted Dir Euch ↓vorstelle

But every day could you yourself ↓imagine

But you could imagine doing it every day

55 Patient Ja

Yes

56 Physio **Mhm**

57 (4.5)

58 Physio tss (.) kk (.) und was für nes Ziel?

tss (.) kk (.) and what for a goal?

tss (.) kk (.) and what kind of goal?

59 (0.8)

60 Physio Was möchteder erreiche mit de Therapie

What would like you achieve with the therapy

What would you like to achieve with therapy

61 (0.3)

62 Patient Aso natürlich scho- (.) dass de dur das dass es denn nümme so (.) verspannt isch

So naturally already- (.) that then through this that it then not any more so (.) tensioned is

So naturally already- that because of the fact that it is then not so tight any more

63 (1.1)

64 Patient eventuell ebe au mit de Ohre besser- aso d'Grüsch es-

probably PART as well with the ears better- well the noises it-

that it *ebe* probably will get better as well with the ears- I mean the noises-

65 (0.3)

66 Physio **Mhm**

67 (0.9)

68 Patient besser wird

better will be

they will get better

69 (10.6)

70 Physio Aso mol de (.) .hh Zämehang eh- eventuell ↑bestätige

So PART the (.) .hh connection eh- probably ↑confirm

So probably *mol* to confirm .hh the link

71 (0.9)

72 zum luege dass wemme: (.) die Verspannige chönnt lindere dass das Grüsch au weniger ehm

to see that if we (.) the tension could ease that the noise also less uhm

to see that if we decrease the tension that the noise would also

73 [würdi werd]e ja [ja]

[would b]e yes [yes]

be less yes yes

74 Patient [Ja ja genau] [Mh]m

[Yes yes exactly] [Mh]m

75 (7.1)

B07 PTd Rx1_1.05 / Initial sequence

1 Physio Werum chömed ihr zu mir id Therapie?

Why come you to me in the therapy?

Why do you come to me for therapy?

2 (0.5)

3 Patient Auso agfange het das (.) jo i sege jetz mol vor öpp::e zwe Mönet

PART begun had it (.) PART I say now PART ago abou::t two months

***Auso* it began (.) *jo* I would say now *mol* about two months ago**

4 (0.2)

5 Physio **↑Mhm**

6 Patient De hani eifach gmerkt nachem Jogge

Then have I MOD realised after the jogging

Then I have *eifacht* realised after running

7 (0.2)

8 Physio **↑Mhm**

9 Patient und zwar

and indeed

in fact

10 (0.7)

11 Patient zerscht nach de grosse Läuf aso i sege jetz mol öppe so 11 Kilometer

at first after the big races PART I say now PART approximately 11 kilometers

at first after the long races *also* I say now *mol* after approximately 11 kilometers

12 Physio **↑Mhm**

13 Patient Das hani am andere Tag (.) nume no schlecht chönne laufe und i han immer geseit es sig d'Hüft aber

That have I on the other day (.) only still bad could walk and I have always said it were the hip but

Then the other day (.) I was only able to walk badly and I always said that it was the hip but (.)

14 (.) nächer het de Doktor feschtgtellt es isch ned (.) d'Hüft vu un[ne (.)]=

(.) afterwards has the physician detected it is not (.) the hip from be[low (.)]=

afterwards the physician discovered that it was not the hip from underneath

15 Physio **[↑Mhm]**

16 Patient =aber obe hinderem Chnoche öp[pis]

=but up behind the bone somet[hing]

=but it was something on the upper part behind the bone

17 Physio **[↑Mhm]**

18 Patient ich ha dem gäng ned eso Beachtig gschenkt und ha denkt ich tue halt echli schone=

I have this always not so attention given and have thought I do PART a bit rest=

I have not given this much attention and I thought that I *halt* rest a bit

19 =susch walki halt de [.hh]

=otherwise walk I PART then [.hh]

otherwise I will then *halt* do walking .hh

20 Physio **[↑Mhm]**

21 Patient aber das het eigentlich au ned meh ↑brocht

but this has actually also not much ↑brought

but this actually did not help much either

22 Physio Ja

Yes

B07 PTd Rx1_14.22 / Second sequence

1 Physio Gue::t (.) .hh aso jetzt hemmer- ebe eig- wenn i (.) das nomol tue zämefasse

Goo::d (.) .hh so now have we- PART act- if I (.) this again do summarise

Goo::d (.) .hh so now let's- *ebe* act- if I summarise this once again

2 s'Jogge wos ebe meh uflöst vor allem 11-12 Kilometer 5-6 tuets liecht uslöse

the jogging that it PART more triggers especially 11-12 kilometers 5-6 does lightly trigger

the running which triggers it *ebe* more especially after 11-12 kilometres after 5-6 it triggers it only slightly

3 Patient **Mhm**

4 (0.2)

5 Physio .hh Guet hettnech eigentlich s'Dehne toh und d'Wärmi

.hh Good did you actually the stretching do and the heat

.hh Good for you was actually the stretching and the heat

6 Patient Mhm ja.

Mhm yes.

7 Physio Oder gits susch no öppis wo der chöit säge das tuet mer=

Or is there otherwise still something that you can say that does me=

Or is there still anything else you could say that it is=

8 Patient Nei

No

9 Physio =guet.

=good

=good for you.

10 Patient Das isch das

That is this

That's it

11 Physio **↑Mhm**

12 Patient S'einzige

The only

The only thing

13 Physio Guet

Good

B07 PTe Rx1_17.49 / Third sequence

1 (3.2) *Therapist writes in her chart*

2 Physio Guet (.) zum Schluss no vum Gspröch (.) üches Ziel? was möchted ihr do (.)

Good (.) at the end still of the discussion (.) your goal? what would like you here (.)

Good (.) at the end of the discussion (.) your goal? now what would you like

3 [erreiche]

[to achieve]

4 Patient [Jo dass i eigentlich] cha unbeschwe(h)rt mim Sport ↑nochegol(h)oh hehe] .hh

[PART that I actually] can caref(h)ree my sport ↑g(h)o a [(h)er hehe] .hh

***Jo* that I can actually follow my sport with no problems hehe .hh**

5 Physio [Jo (.) guet]

[Yes (.) good]

6 (0.9) ((*physiotherapist is writing in chart*))

7 Physio [Aso bim Jogge] bliebe s[o]

[So with jogging] stay s[o]

So to continue with running like this

8 Patient [Eh aso- eh] [Jo]:o aso .h ich has nocher echli mit Schwümme das isch tiptop=

[Uh so- uh] [Ye:]es so .h I have afterwards a bit with swimming that is super=

Uh so- uh **Yes so .h I tried afterwards a bit of swimming that went super**

9 =[gang]e sobald i (.) Ding wegnimme- (.) Schwümme hät notürli au wieder ge-ge- =

=[wen]t as soon I (.) thing away took- (.) swimming has certainly as well agai- agai-=

as soon as I (.) took the thing away (.) swimming is certainly as well agai- agai-=

10 Physio **[↑Mhm]**

11 Patient =isch wieder schwärelos ↑od[er]

=is again weightless ↑isn'[t it]

12 Physio [Mhm] ja

[Mhm] yes

13 (0.7)

B08 PTd Rx2_9.58

1 Physio Dörfed echli mithelfe

Are allowed you a bit to help with

You are allowed to help a bit

2 (2.0) *((Physiotherapist is mobilising patient's elbow))*

3 Physio °Genau°

°Exactly°

4 (0.8)

5 Physio Guet

Good

6 (3.6)

7 Physio .hh Und was isch Eues ↑Ziel

.hh And what is your ↑goal

8 (0.5)

9 Physio Was möchteder wieder mache nächher wenn das-

What would like you again do afterwards when this-

What would you like to be able to do again afterwards when this-

10 Patient Alles woni jetzt gmacht [↑ha]

Everything that I now done [↑have]

Everthing I did before

11 Physio [Aues] woder bisher gma[cht heid]

[Everything] that you before do[ne have]

Everything you did before

12 Patient [Aso go turne goni] nümm.

[So to do gymnastics go I] not anymore.

So I am not going to do gymnastics anymore.

13 (0.6)

14 Physio ↑Eh[e]

↑Uh[um]

15 Patient [Will] mir si amal nümme mengs (.) und denn isch es echli längwielig.

[Because] we are at times not anymore many (.) and then is it a bit boring.

Because we are not many anymore at times (.) and then it is a bit boring.

16 (0.4)

17 Physio **Ehe [mhm]**

18 Patient [Denn] chame nüme so .hh Spieli mache [und-]

[Then] can one not anymore so .hh games do [and-]

Then we cannot play games anymore and-

19 Physio [Grad] no wietermache [dezue näh]

[Just] still continue do [additional take]

Just continue add this one

20 Patient [denn] chame =

[then] can one =

then we cannot play

21 =nümme so Spieli mache und denn [isch's] längwielig

=not anymore such games do and then [it is] boring

any more games and then it is boring

22 Physio **[↑Mhm]**

23 (0.6)

24 Physio **Mhm**

25 (2.8)

26 Patient Nenei i wött denn wieder wieter ↑liesme i ha- (.) [e-]

No no I would like then again continue ↑knitting I have- (.) [a-]

No no I would like to continue knitting again I have a-

27 Physio [Wie] lang tüeter denn aube so am Stück lisme

[How] long do you then normally so in a row knit

For how long at one time do you normally knit

28 (0.9)

29 Patient Jo jenachdem.

PART depends on it.

***Jo* it depends.**

30 (1.1)

31 Physio Ungefähr so

Approximately so

32 (0.3)

33 Patient E Stund?

An hour?

34 (0.2)

35 Physio E Stund.

An hour.

36 (0.2)

37 Patient [Jo:o] jo

[Ye:es] yes

38 Physio [Ja.]

[Yes.]

39 (0.7)

40 Patient De leggis wieder ↑ab (.) denn gangi öppis go ↑trinke und- (.)

Then put I it again ↑down (.) then go I something go ↑drink and- (.)

Then I put it down again then I go to drink something and-

41 .hh de chunnt wieder öpper un[d-]

.hh then comes again somebody an[d-]

.hh then somebody stops by again and-

42 Physio **[Mhm]**

43 (0.3)

44 Physio Dir heit scho chli z'tüe i dem Fall he[hehe] [Mhm]

You have already a bit to do in this case he[hehe] [Mhm]

You have quite a lot to do in this case hehehe **Mhm**

45 Patient [Jo] ich maches scho zwölf J[ahr]=

[Yes] I make already twelve ye[ars]=

Yes I have been making it already for twelve years

46 =eifacht wiessi Pullöverli

=MOD white small sweaters

***eifacht* small white sweaters**

47 (1.7)

48 Physio Mached[er]

Make y[ou]

You do them

49 Patient [Un]d denn chömed sie die bi der Taufi über

[An]d then come they those at the baptism get

And then they receive them at the baptism

50 Physio Mhm mhm (.) [he]rzig ja

Mhm mhm (.) [cut]e yes

51 Patient [Ja]

[Yes]

B09 PTe Rx1_20.06

1 Physio .hhh Het eh:m de Doktor D gseit was er nöd dörfed mache. (.)

.hhh Have uh:m the Doctor D said what you not are allowed to do. (.)

.hhh Did uh:m Doctor D say what you are not allowed to do.

2 m o m e n t [an.]

at the mome[nt.]

3 Patient [Er] het mer gseit eifacht ned morkse oder

[He] had me told MOD not push huh

He told me *eifacht* not to push it huh

4 (0.4)

5 Physio Ned mork[se (.)] ned lüpfe [eso das eifach.]

Not to pu[sh (.)] not to lift [just this MOD.]

Not to push it (.) not to lift just like that *eifach*

6 Patient [Ja] [ja (.) ja]

[Yes] **[yes (.) yes]**

7 Physio **↑Mhm**

8 (8.2) *((Physiotherapist writes in chart))*

9 Physio Gue:t

Goo:d

10 (0.7) *((Physiotherapist turns page, still looking down))*

11 Physio .h Üches Ziel? (.) Herr X

.h Your goal? (.) Mister X

12 (0.4) *((Physiotherapist shuffles paper and looks up))*

13 Physio do ide [Therapie]

here in the [therapy]

14 Patient [Jo eifacht] (.) ganz schmerzfrei werde oder (.) [ganz klar] oder

[PART MOD] (.) totally pain free to become huh (.) [totally clear] huh

***Jo eifacht* to become completely pain free huh (.) that's clear isn't it**

15 Physio [Schmerzfrei] werde

[Painfree] to become

To become pain free

16 **↑Mhm** *((Physiotherapist starts writing before mhm))*

17 (1.2) ((*Physiotherapist writes in chart*))

18 Patient Ohni Medi ohni irgend- aso guet ich bi jo sowieso gege das ich nimme würklich=

Without medication without any- PART good I am PART anyhow against that I take really=

Without medication without any- *also* alright I am *jo* anyhow against that I only take

19 =nume s'Minimum [woni muess näh]

=only the minimum [that I must take]

the minimum I have to

20 Physio [Woder müesst vu Medik]ament (.) guet (.) [ok(h)ay]

[That you have to of medic]ation (.) good (.) [ok(h)ay]

((Physio looks up)) **That you have to take the medication (.) good (.) o(h)kay**

21 Patient [Das isch scho gnueg guet]

[This is already enough good]

This is already good enough

22 (0.4)

23 Patient gnue

enough

24 Physio .hh Aber no schmerzfrei wärde (.) das heisst dass das Steche weg goht?

.hh But still pain free to become (.) that means that the stabbing away goes?

.hh But still to become pain free that means that the stabbing pain disappears?

25 Patient Jo

Yes

26 Physio So das no

So that still

That's that

27 Patient Dass eifacht (.) de ganz Bewegigsapparat dass i de wieder- au wenni d'Chraft wirde=

That MOD (.) the whole movement machine that I then again- even if I the force will=

That *eifacht* (.) the whole musculoskeletal system that I can again- even if I lose the force

28 =verlüre (.) dass i de eifacht bhaute das isch [wichtig]

=lose (.) that I then MOD keep that is [important]

that I *eifacht* keep it this is important

29 Physio [Guet (.) ↑mhm]

[Good (.) ↑mhm] *((Physiotherapist starts to write))*

30 Patient Das isch würklich s'Ziel od[er]

That is really the goal h[uh]

31 Physio **[M]hm.**

32 (3.6) *((Physiotherapist writes in chart))*

33 Patient Dass nächher no chli öppis wird fähle isch jo ↑klar oder aber i wott eifacht [dass i-]

That afterwards still a little bit will miss is PART ↑clear huh but I want MOD [that I-]

That there will still be a bit missing afterwards that's *jo* clear huh but I *eifacht* would like that I-

34 Physio [Dass Ihr] wieder=

[That you] again=

That you could

35 =chönd funktioniere im Alltag he

=could function in every day huh

function again in day-to-day activities huh

36 Patient Jo

Yes

37 (5.8) *((Physiotherapist writes in chart))*

38 Physio Guet (.) .hhh heit ihr no e Kontrolltermin bim Dr. D

Good (.) .hhh have you still a control appointment with Dr. D

Good (.) .hhh do you have a medical appointment with Dr. D

B10 PTg R1_3.02 / Initial sequence

1 Physio Guet. (.) können sie mir (.) sagen was aus ihrer Sicht jetzt (.) das Problem ist was sie-

Good (.) could you me (.) say what from your sight now (.) the problem is what you-

Good (.) could you tell me from your point of view now what the problem is that you-

2 Patient Aso ich ha Schwindelafäll Chopfweh und schlecht.

So I have dizziness headache and nausea

So I feel dizzy I have a headache and feel nauseous

3 (0.4) *((Physiotherapist starts to write in chart))*

4 Physio Sie haben Schwindelanfälle Kopfweh und es ist ihnen übel also schlecht

You have dizziness headache and it is you bad well nauseous

You feel dizzy have a headache and you feel bad well nauseous

5 (0.3)

6 Physio Ja.

Yes.

7 (3.5) *((Physiotherapist continues writing))*

8 Physio **↑Mhm**

9 (7.2) *((Physiotherapist finishes writing and looks at patient before starting to talk))*

10 Physio Gehen wir mal der Reihe nach durch.

Go us even the row after through

Let's go through one thing at a time

11 Patient **Hehehe**

B10 PTg Rx1_40.45 / Second sequence

1 Physio Guet. (.) wenn ich jetz mal so ein bisschen zusammenfasse (.)

Good (.) if I now once such a bit summarise (.)

Good (.) if I summarise a bit

2 dann könne wirs ja- vielleicht so ein bisschen auch mal einen Eindruck (besitze) (.)

then could we it so- probably such a bit as well even an impression (have) (.)

then we could so- probably just a bit get the impression

3	aso das primäre Problem ist wirklich so wie sie dies in der Reihenfolge schon fast genannt haben=	
	so the primary problem is really as how you it in the order just nearly said have=	
	so the main problem is really as you have said it in this order	
4	ist ein Schwindelproblem ja?	
	is a dizziness problem yes?	
	is a problem of dizziness right?	
5	(0.2)	
6 Patient	Ja	
	Yes	
7	(0.2)	
8 Physio	Und der Kopfschmerz und vor allem die Übelkeit hängen hintendran.	
	And the headache and especially the nausea hang behind on it	
	And the headache and especially the nausea are connected to it	
9 Patient	Ja.	
	Yes	
10 Physio	Genau gesagt Kopfweh geht wie in Schwindel über	
	Correctly said headache goes like in dizziness over	
	To say it correctly the headache leads to dizziness	
11 Patient	Jawohl	
	Exactly	
12	(0.8)	
13 Physio	**Mhm**	

B10 PTg Rx2_4.22 / Third sequence

1 Physio Guet. (.) Ich frag sie das nicht nächstes Mal wieder sondern [erst gegens Ende der Si-] der Therapie.

Good. (.) I ask you this not next time again but [only towards the end of the se-] the therapy.

Good. (.) I am not going to ask you this again until the end of the se- the therapy.

2 Patient **[h e h e h e h e h e]**

3 (0.9) *((Physiotherapist turns away from patient, puts the chart on the bed and starts writing))*

4 Patient Okay

Okay

5 (1.0)

6 Physio Eh:::::m hh.

Uh::::m hh.

7 (1.0)

8 Physio Die nächste Frage ist ↑die (.) was erwarten sie von der Therapie im Moment.

The next question is ↑this (.) what expect you from the therapy at the moment.

The next question is this one (.) what do you expect from therapy at this time

9 was ist ihr Ziel. was möchten Sie erreichen.

was ist your goal. what would like you to achieve.

what is your goal. what would you like to achieve.

10 (0.9)

11 Patient Dassi mini Bewegige wieder cha mache

That I my movements again can make

That I can move again

12 (2.0)

13 Physio Ihre Bewegungen das heisst?

Your movements that means?

Which means that you can move again?

14 (0.2)

15 Patient Auso dass mer ned immer wieder schwindlig wird

So that me not always again dizzy get

So that I don't get dizzy all the time

16 (0.7)

17 Physio **↑Mhm**

18 (1.4)

19 Patient >Dass i nüme so igschränkt bi<

>That I not any more so restricted am<

That I am not so restricted anymore

20 (2.9)

21 Physio Also weniger Schwindel.

So less dizziness.

So less dizzy.

22 Patient Ja

Yes

23 (0.7)

24 Physio Wenn Sie weniger Schwindel (.) ↑hä□en (.) was würden Sie dann machen.

If you less dizziness (.) ↑had (.) what would you then do.

If you were less dizzy what would you do then.

25 (1.3) *((Physio continues to look at the patient until patient starts to speak))*

26 Patient De würdi (.) d'Sache wieder schneller mache

Then would I (.) the things again faster make

Then I would do things faster again

27 (1.0)

28 Patient D'Arbeit schneller mache

The work faster make

Do the work faster

29 (0.8)

30 Physio Zum Beispiel Betten (.) schneller m[achen oder was]

For example beds (.) faster ma[ke or what]

For example to make the beds faster or what

31 Patient [Ja oder] jo

[Yes or] yeah

32 (0.4)

33 Patient D'Chuchiarbeite-

The kitchen work-

The kitchen work

34 (1.0)

35 Physio Im Moment sind Sie langsam

At the moment are you slow

At the moment you are slow

36 Patient Jo de machi immer [alles] längsämer

Yeah then do I always [everything] slower

Yeah I do everything slower all the time

37 Physio **[Mhm]**

38 (2.4)

39 Physio Also Ihren Haushalt (.) quasi schneller [(.)] über die Runden bringen ↑mhm

So your household (.) like faster [(.)] over the rounds bring ↑mhm

So to do your housework faster mhm

40 Patient [Ja]

[Yes]

B11 PTd Rx1_4.43

1 Physio	E:hm sit Dir bruefstätig?
	U:hm are you occupied?
	U:hm do you work?
2 Patient	Ja
	Yes
3	(0.8)
4 Physio	W=viel Prozent schaff[ed Der?]
	H=w many percent wor[k you?]
	At what percentage do you work?
5 Patient	[Hundert Pro]zent
	[Hundert per]cent
6 Physio	Hundert Prozent.
	Hundert percent.
7	(0.6)
8 Physio	Und was mached Der brueflich
	And what make you professionally
	And what are you doing professionally
9 Patient	°Ich bi Personalberateri°
	°I am personnel consultant°
	°I am in human resources°
10	(1.5)
11	°Ufem Amt für Wirtschafts (frage)°
	°At the office of economic (questions)°
	°At the office of commerce°
12	(2.6)
13 Physio	**↑Mhm**
14	(2.1)
15 Physio	U was mache Der ir Freiziet?
	And what make you in the leisure time?
	And what are your hobbies?

16 (3.7)

17 Patient E:hm

U:hm

18 (4.6)

19 Patient Das isch e gueti Frog

T**his is a good question**

20 (0.8)

21 Patient Jo guet d'Freiziet isch natürlich echli eh knapp bemesse aber i [lise] ↑viel

PART good the leisure is naturally a bit uh little measured but I [read] ↑a lot

***Jo* actually I do not have a lot of leisure time but I read a lot**

22 Physio **[Mhm]**

23 (0.5)

24 Physio **↑Mhm**

25 (1.8)

26 Patient Eigentlich wenni- (.) normalerwies- wenni Ziet ha gömmer viel go ↑laufe

Actually if I (.) normally- if I time have we go a lot to ↑walk

Actually if I normally- if I have time we go often for a walk

27 (0.4)

28 Physio **↑Mhm**

29 (3.1)

30 Physio Wie lang oder wie wiet göter aube so go ↑spaziere (.) oder laufe

How long or how far go you normally go to ↑stroll (.) or walk

For how long or how far do you normally go for a stroll (.) or walk

31 (0.3)

32 Patient ↓Jo scho e gueti Stund

↓PART s□ll a good hour

***Jo* a good hour**

33 (2.3)

34 Physio **↑Mhm**

35 (0.3)

36 Patient Aber es chunnt notürlich scho viel Mol z'churz

But it comes naturally even a lot of times too short

But it does actually not happen as many times

37 (0.6)

38 Physio M**hm**

39 (1.4)

40 Patient Und süsch e:hhhm

And otherwise u:hhmm

41 (2.2)

42 Patient Sportlichi Aktivitäte und so hani eifacht aube immer gern gmacht=

Sports activities and so on have I MOD normally always liked=

I always liked sports activities and so on

43 =und das chunnt eifacht scho z'churz jetze

=and this comes MOD well too short now

but at the moment it is *eifacht* missing

44 (0.7)

45 Patient Das isch eigentlich scho es Problem

This is actually still a problem.

This is actually a problem.

46 (1.9)

47 Patient Uf jede Fall [(chömed viel) Problem zäme eigentlich (.) im ↑Moment]

In any case [(come a lot of) problems together actually (.) at the ↑moment]

In any case there are a lot of problems coming together actually at the moment

48 Physio [Aso aktuell mached Der gar kei sportlichi Aktivität] oder

[So currently make you not at all sports activities] huh

So at the moment you don't do any sports activities at all huh

49 (1.1)

50 Patient Gar nüt m[eh]

At all nothing m[ore]

Nothing at all

51 Physio [Gar] nüt (.) und was heiter amel gmacht gha?

[At all] nothing (.) and what have you normally done ?

Nothing at all (.) and what did you normally do?

52 oder was heiter [gern gmacht gha]

or what have you [liked to do]

or what did you like to do

53 Patient [Ja viel] Velofahre [(.) Vo]lleyballspiele

[Yes a lot] bicycling [(.) vo]lleyball

54 Physio **[Mhm]**

55 (8.7) *((Physiotherapist writes in her chart))*

56 Physio **↑Mhm**

57 (0.3)

58 Patient Gymnastik aube no (chli)

Gymnastics normally a (bit)

Normally a bit of gymnastics

59 (5.6*) ((physiotherapist writes in chart))*

60 Physio Heiter no en Kontrolltermin in nächschter Zi[et ein]isch bim Ar[zt?]

Have you still a control appointment in next ti[me on]ce with the doct[or?]

Do you already have another medical appointment scheduled for the near future?

61 Patient [Ja] [Nöch]scht Mänt[ig]

[Yes] **[Nex]t Monda[y]**

62 Physio [Nö]chscht Mäntig

[Ne]xt Monday

63 (0.9)

64 Physio Isch der-

Is the-

It is the-

65 (0.4)

66 Patient Achtezwänzgisch[t]

Twenty - eigh[th] *((of the month))*

67 Physio [Ach]tezwänzgischt

[Twen]ty-eighth

68 (4.3) ((*Physiotherapist writes in chart, then turns back to patient))*

69 Physio Was isch eues Ziel?

What is your goal?

70 (1.3)

71 Patient Mis Ziel?

My goal?

72 Physio **↑Mhm** *((Physiotherapist nods))*

73 Patient Dass ich cha si ohni Schmärze

That I can be without pain

((Physiotherapist turns to chart to write))

B16 PTe Rx1_16.35

1 Physio Süsch n:o öppis woder vorether gmacht heit vorem ↑Sturz

Else still anything that you before made had before the ↑fall

Anything else that you did before the fall

2 [woder jetzt nüme ↑chöit]

[that you now not any more ↑could]

that you are not able to do anymore

3 Patient [Ehm jo] fitness hani gmacht aber das hani ufgeh

[Uhm PART] fitness have I done but that have I up give

Uhm *jo* I did some fitness training but I have given it up

4 Physio **↑Mhm**

5 Patient °Für die Ziet°

°For the time°

For the time being

6 Physio Ja.

Yes.

7 (4.1)

8 Physio Okay (.) .hh Was isch üches Ziel do vu de Therapie

Okay (.) .hh What is your goal here of the therapy

Okay (.) .hh What is your goal here for therapy

9 (1.7)

10 Patient °Kei Ahnig he[hehe°]

°No idea he[hehe°]

11 Physio [hehehe] Werum siet ihr do was söll andersch werde [dhh]

[hehehe] Why are you here what should different become [dhh]

hehehe Why are you here what should be different

12 Patient [°Wi]eder (laufe) denki°

[°Ag]ain (walking) think I°

To walk again I think

13 (0.2)

14 Physio **↑Mhm**

15 (3.5) *((Physiotherapist writes in chart))*

16 Physio Heiter e Vorstellig vu de Schmerze her.

Have you an imagination/aspiration of the pain from.

Do you have an idea with regard to your pain.

17 (1.0) *((Physiotherapist shifts gaze to patient))*

18 Patient °Aso wie meined Der Vorstellig°

°PART what mean you imagination°

***Also* what do you mean by an idea**

19 Physio Aso säged[er- ehm (.) jo i] wott schmerzfrei si und-

So say y[ou- ehm (.) yes I] want painfree to be and-

So you say- ehm yes I would like to be painfree and-

20 Patient [Dass sie wäg göi]

[That they away go]

That it goes away

21 (1.5)

22 Physio So chönne schaffe oder heiternech- was heit der do für Vorstellige

So be able to work or have you- what have you here for imagination

To be able to work or do you have- what do you expect

23 (1.0)

24 Patient °Jo ich ha scho mol Physiotherapie gha [(.)] heile tuet me ned gross (.) aber es isch meh°(.)

°PART I have already once physiotherapy had [(.)] cure does it not big (.) but it is more° (.)

***Jo* I have had physiotherapy once before (.) it is not possible to cure it but it is more**

25 Physio **[↑Mhm]**

26 Patient e chlini Hülf für (.) fürs Le:be oder für (.) dass es echli [bess]er geit [eigentlich] aber eh-

a little help for (.) for the li:fe or for (.) that it a bit [bett]er goes [actually] but eh-

a little help for- for living or for the fact that it will actually be a bit better but eh-

27 Physio [Ja] [Mhm]

[Yes] [Mhm]

28 Patient jo i hoffe mer scho dass sie wäg göih

PART I hope me still that they away go

***jo* I still hope that it will go away**

29 Physio **Mhm**

B17 PTb R1_34:40

1 Physio Und bi weller Strecki heiters s'letschte Mol am meischte gmerkt? hh.

And with which route have you the last time the most felt? hh.

And at what route did you feel it the most the last time? hh.

2 Patient Wald obsi

Forest uphill

Uphill in the forest

3 (0.3)

4 Physio Wald obsi

Forest uphill

Uphill in the forest

5 Patient Wald unebe und obsi

Forest uneven and uphill

On uneven grounds in the forest and uphill

6 Patient Das isch s'schlimmschte

This is the worst

7 Physio Do hettmes relatif guet zum Kontrolliere o[der ich ha- ich cha] do scho zwei drü=

Here have we relatively good to control o[r I ha- I can] here already two three=

It will be relatively easy to control or I ha- I can already test two three things

8 Patient [Ja uf all Fäll]

[Yes in any case]

9 Physio =Sache [tescht]e wo sich denn verändere ho[ffentlich] .hh

=things [test] that then change ho[pefully] .hh

that then hopefully will be improved .hh

10 Patient [Jo] [Nei aso eifacht Wald] unebe und obsi

[Yes] [No PART MOD forest] uneven and uphill

[Yes] **No *also eifacht* in forest on uneven surface and uphill**

11 (0.2)

12 Physio ↑Ja (.) [auso (.) wenner das wieder göht go] mache (.)

↑Yes (.) [so (.) if you this again go to] make (.)

Yes so if you are going to do this again

13 Patient [Das chani problemlos das merki sofort]

[This can I problemfree this feel immedately]

I can do this without problems I feel it immediately

14 Physio [chöi]ters verglieche. auso

[coul]d you compare. so

you could compare. okay

15 Patient [Jo]

[Yes]

16 Physio **.hhh**

17 (2.0)

18 Physio S'isch s::o jetzt nach dere Behandlig das chan echli reagiere im ↑Chnöi (.)

It is li::ke this now after this treatment it can a bit react in the ↑knee (.)

It can happen now that after this treatment the knee reacts a bit

19 [es cha] i dem chli reagiere dass bisen Tag oder ebe au en Tag im Nachhinein=

[it can] in this a bit react that up to a day or PART as well a day afterwards=

it can be that it reacts a bit up to one day or *ebe* the day after

20 Patient **[Mhm]**

21 Physio =.hh de Schmerz echli stärcher wird

=.hh the pain a bit stronger become

that the pain increases a bit more

22 Patient **↑Mhm**

23 Physio Chan aber au si dass Der merked dass nech echli ringer geit.

It can but as well be that you realize that it a bit easier goes.

But it can also be that you realize that it becomes a bit easier.

24 Patient **Mh[m]**

25 Physio [Od]er es cha si dass gar nüt passiert [(.) da]ss genau gliech bliebt.

[Or] it can be that at all nothing happens [(.) th]at it exactly same stays.

Or it can be that nothing at all happens that it stays exactly the same.

26 Patient [Ja]

[Yes]

27 Physio .hh Für mi wär eifacht sehr wichtig für die nöchscht Behandlig dass Ihr nech=

.hh For me would be MOD very important for the next session that you yourself=

.hh It would be very important for me for the next session that you

28 =echli druf ↑achtet dasser s'nöchschte Mol chöit säge .hh wenn's schlimmer wird

=a bit to this ↑pay attention that you the next time could say .hh if it worse gets

=pay a bit of attention to it that you could tell me the next time .hh if it gets worse

29 (.) ab wenn und wie lang isch schlechter gsi oder au wenn's besser isch wie lang=

(.) since when and how long it has worse been or as well if it better is how long=

(.) when and for how long is it worse or even if it is better for how long=

30 =hebt's here. [denn chömmer- genau] asmer sochli d'Dosierig de au [chöi]=

=stays it here. [then could we- exactly] that we a bit the dose then as well [could]=

=it stays there. then we could- exactly that we could adjust the dose a bit afterwards as well

31 Patient [Eifacht en Veränderig feschthalte] [↑Mhm]

[MOD a change to hold] [↑Mhm]

***Eifacht* to note a change** **↑Mhm**

32 Physio =apasse ahand vu dem nochher

=adjust according to this afterwards

in line with this

33 (2.5)

34 Patient Ich glaube am Mäntig hani denn wieder en Termin

I believe on Monday have I then again an appointment

I believe that I have another appointment on Monday

35 (1.5)

36 Physio Heiter es bestimmts ↑Ziel? (.) vor ↑Auge?

Have you a certain ↑goal? (.) in front of the ↑eye?

Do you have a certain goal? in mind?

37 (0.3)

38 Patient ↑Nei

↑No

39 (0.8)

40 Patient ↑Fit

↑Fit

41 (0.2)

42 Physio Fi[t]

Fi[t]

43 Patient [Fit] bliebe

[Fit] stay

To stay fit

44 (0.2)

45 Physio Eifach wieder Eui Trainings (.) wieder [normal chönne mache i dem Sinn]

MOD again your trainings (.) again [normally can do in that sense]

***Eifach* to be able to do your training again in that way**

46 Patient [Nei ich ha keis Ziel nei ich mache weder] Läuf Wettkämpf-

[No I have no goal no I do neither] races competitions

No I do not have any goal no I do neither races nor competitions-

47 (0.2)

48 Physio Ja

Yes

49 Patient Das hani würklich wieder springe und alls eso chli (.) uf d'Siete gleit.

This have I really again running and all of that a bit (.) on the side put.

I really put the running and all of it aside

50 Physio Ja

Yes

51 (0.4)

52 Physio Aber würded eifacht gern Euchi Train[ings schmerzfrei chönne mache]

But would you MOD like your train[ings painfree can do]

But you would *eifacht* like to be able to train without pain

53 Patient [Ja am liebschte würdich wieder go spri]nge ja

[Yes the most would I again go runni]ng yes

Yes I would like to be able to go running again yes

54		(0.2)
55	Physio	Das sogar (.) ja
		That even (.) yes
		Even that (.) yes

B18 PTb Rx1_19:50 / Initial sequence

1 Physio Was würded Ihr gern erreiche? (.) oder was wär sochli d'Erwartig ad Physiotherapie für Euch?

What would you like to achieve? (.) or what would be a bit the expectation for physiotherapy for you?

What would you like to achieve? or what would be a bit about what you expect from physiotherapy?

2 (2.0)

3 Patient I wett eigentlich das erreiche dassi mal (.) ohni Schmerze chönnt si

I would like actually this to achieve that I once (.) without pain could be

I would actually like to achieve that I would be for once pain free

4 Physio **↑Mhm**

5 (3.0) *((Physiotherapist turns to write in chart, patient retakes floor while therapist is still writing))*

6 Patient Das wär eigentlich mis- mis Ziel alles andere isch mir im Pri(h)nzip gliech (.)

This would be actually my- my goal everything else is me in pri(h)ncipal unimportant (.)

This would actually be my- my goal everything else is principally unimportant to me

7 ich wett eigentlich nume mal (1.0) ohni (.) Schmerze si

I would like actually only once (1.0) without (.) pain to be

I would actually like to be just once (1.0) without pain

8 Physio Ganz ohni Schmerze [ja] ((*therapist starts talking while still writing*))

Totally without pain [yes]

9 Patient [Genau]

[Exactly]

10 Physio Was würded ihr denn mache wenn das mol so wär?

What would you then do if this PART like this were?

What would you do if it were *mol* like that?

11 (1.0)

12 Was wär s'erschte woder miechted?

What would be the first that you did?

What would be the first thing you did?

13 (1.0)

14 [wenn der keini Schmerze meh hätted?]

[if you no pain anymore had?]

if you were without pain?

15 Patient [Gliiech wie jetzt]

[Same as now]

16 Physio Ja

Yes

17 Patient Aso eifacht ruhiger si echli [meh gniesse]

So MOD more quiet be a bit [more to enjoy]

So *eifacht* to be quieter to enjoy a bit more

18 Physio [E Stund länger schlofe] ja (.) ja

[One hour longer sleep] yes (.) yes

To sleep one hour longer yes (.) yes

19 Patient Ja

Yes

B18 PTb Rx2_7:01 / Second sequence

1 Physio .hh Aber wenn is richtig verstoh giengs dem Fall würlich drum dass mer es globals Training=

.hh But if I it right understand would be the case really the reason that we a global training=

.hh But if I understand correctly it would be in that case the reason that we had afterwards a

2 =nächene hätte [schlussendlich]

=afterwards would have [at the end]

global training schedule at the end

3 Patient [Jawohl]

[Yes]

4 Physio Auso

Okay

5 Patient Und eifacht ebe mis Ziel woder mi s'letscht Mol frogt [hend]=

And MOD PART my goal that you me the last time asked [have]=

And *eifacht ebe* my goal that you asked me about the last time=

6 Physio **[↑Mhm]**

7 Patient =das wär eigentlich (.) as mir de Schmerz nüme mis Lebe bestimmt sondern (.) ig (.) mis=

=that would be actually (.) that me the pain not anymore my life controls but (.) I (.) my=

=that would actually be that the pain does not control my life anymore but that I control

8 =Lebe selber cha bestimme [oder] =

=life alone can control [huh]=

my life again by myself huh

9 Physio [Ja]

[Yes]

10 Patient =und wieder cha mache wini- will (.) ich ha mir nochher au überleit es isch mir gar nie=

=and again can do as I- would like (.) I have me afterwards also thought it is me never ever=

and I can do again as I- wish (.) I thought about it afterwards I was never ever conscious

11 =bewusst worde >ich ha scho soviel ufgeh<

=conscious get >I have already so much up give<

about the fact that I gave up already so much

12 Physio **Mhm**

13 Patient [Oder]

[Huh]

14 Physio [När]

[Afterwards]

15 Patient I gang nie furt ich mach nüt ab=

I go never out I make nothing up=

I do not go out I do not plan anything

16 Physio Ja ja

Yes yes

17 Patient =i gang nümm go Töff fahre ich ha mi Spinnezucht ufgeh=

=I go never to motorcycle ride I have my spider rearing up give=

I do not ride my motorcycle anymore I gave up my spiders

18 =[eifa]cht extrem viel aber irgendwie tueni- jo ich ha mich nie mit däm-

=[MOD] extremely a lot but somehow do I- PART I have me never with this-

***eifacht* extremely a lot but somehow I do- *jo* I have never with it-**

19 Physio **[Mhm]**

20 Physio Ja isch das eifacht wie dominanter worde gäng de Schmerz [wo=]

Yes is this MOD like more dominant get always the pain [that=]

Well the pain *eifacht* got more dominant that it has

21 Patient [Genau]

[Exactly]

22 Physio =eifacht gäng echli meh Kontrolle übercho übers lebe ja .hh das isch sicher=

=MOD always a bit more control get over the life yes .hh this is sure=

***eifacht* gotten always a bit more control over your life yes .hh this is indeed**

23 =ganz es guets Ziel .hhh [und-]

=totally a good goal .hhh [and-]=

a very good goal .hhh and-

24 Patient [Und] ned numme eifacht- jo de Schmerz weg [oder]

[And] not only MOD- PART the pain away [huh]

And not only *eifacht- jo* the pain away huh

25 Physio [Ja]

[Yes]

26 Patient Eifacht- i wett eifacht wieder chönne (.)

MOD- I would like MOD again could (.)

***Eifacht*- I would like *eifacht* again (.)**

27 Physio Genau

Exactly

28 Patient selber bestimme im Prin[zip]

by myself decide in princi[pal]

to decide by myself in principal

29 Physio **[Mhm]**

30 Physio Ich denke das isch es guets Ziel vor allem wills ebe de Aspekt dinne het mir chöi ned de=

I think this is a good goal especially because it PART the aspect in it had we could not the=

I think that this is a good goal especially because it is *ebe* the aspect we cannot *eifacht* take away

31 =Schmerz wahrschienlich vu hüt uf morn eifacht wegneh auso de Schmerz wird sicher die=

=pain probably from today to tomorrow MOD take away so the pain will surely the=

the pain probably from today to tomorrow so the pain will certainly belong to you for

32 =nöchschti Ziet dezue ↑ghöre .hh d'Frog isch eifacht ebe wie gömmer mit dem um?=

=next time to it ↑belong .hh the ques□on is MOD PART how go we with this on?=

a time .hh the question is *eifacht ebe* how do we deal with it?=

33 Patient **Mhm**

34 Physio =und was chöimer trotzem Schmerz ebe mit echli meh Kontrolle oder ebe au .hh mitere=

=and what can we despite the pain PART with a bit more control or PART as well .hh with a=

and what can we try afterwards despite the pain *ebe* with a bit more control or *ebe* as well .hh=

35 =andere Istellig probiere nächene=

=other attitude try afterwards=

with another attitude

36 Patient Jawohl

Yes

37 Physio =trotzdem wieder echli meh vum lebe zha (.) [he?]

=despite again a bit more of the life to have (.) [huh?]

to have again a bit more from life despite of the pain (.) huh?

38 Patient [Genau]

[Exactly]

39 Physio .hhh Auso [aber de-]

.hhh So [but then-]

40 Patient [Jetzt tueni] mental amel wenn i is Bett go oder so bevor i schlo- tuen i immer-

[Now do I] mentally whenever when I to bed go or so before I slee- do I always-

Now I do some mental exercises whenever I go to bed or so before I slee- I always do

41 (0.4) dass mer so vorsäge oder dass mi (.) d'Chrankheit ned cha beherrsche=

(0.4) that me so recite or that me (.) the illness not can control=

(0.4) that I say to myself or that the illness does not have control over me

42 Physio Ja

Yes

43 Patient =de Schmerz chasch mi ned beherrsche=

=the pain can you me not control=

the pain you don't have control over me

44 Physio [Ja]

[Yes]

45 Patient [=eso] viellicht tuets jo-

[=PART] probably does it PART-

***eso* probably this does *jo*-**

46 Physio ↑Jo das isch guet

↑Yes this is good

B19 PTb Rx1_5.56

1 Physio Was wär s'Ziel de jetzt vudere (.) Therapie[phase no einisch]

What would be the goal then now of this (.) therapy [phase once again]

What would be the goal for now for this therapy phase this time

2 Patient [He jo ↑stabili]siere (.)

[He PART to ↑stabili]se (.)

He *jo* to stabilise

3 m[eh gi]t- meh liet jo nümm din[ne]

m[ore is-] more lies PART not any more in [it]

more there is- there is *jo* not much more possible

4 Physio [Ja] [↑Mh]m

[Yes] **[↑Mh]m**

5 (2.9)

6 Patient Aso i denke meh liet nümme dinne

PART I think more lies not any more in it

***Also* I think there is not much more possible**

7 (0.4)

8 Physio Ja

Yes

9 (1.8)

10 Physio Dass mer eifacht so s'Niveau chönnted erhalte jetze [im Mo]ment .hh

That we MOD so the level could keep now [at the mo]ment .hh

That we *eifacht* could keep the level now at the moment .hh

11 Patient [Ja]

[Yes]

12 Physio S'Niveau wo steit das öppe oder wo isch das im Moment

The level where stands this approximately or where is this in the moment

This level where is it about located or where is it at the moment

13 wenn er sochli so d'Haupttätigkeite us Euchem Alltag alueged

when you a bit so the main activities from your day look

when you look a bit at the main activities you have to do during the day

14 (1.9)

15 Patient Es isch eso (.) dass i eifacht (.) gwüssnigi Sache nüme ganz s::elber cha mache

It is like this (.) that I MOD (.) certain things not any more completely a::lone can make

It is that I cannot *eifacht do* certain things completely by myself anymore

16 [wenn's-] (.) wenn's körperlichi Sache [si]

[if there-] (.) if there physical things [are]

If it- if it is physical

17 Physio [Mhm] [Ja] was isch das zum Biespiel?

[Mhm] **[Yes] what is this for example?**

18 isch das meh bim Schaf[fe?]

is this more at wo[rk?]

is it more at work?

19 Patient [Wenn i gäng] lüpfe od[er] (.) oder irgendwie-

[When I always] lift o[r] (.) or somehow-

20 Physio [Ja]

[Yes]

21 (2.7)

22 Patient Eh:::::hm was chönnts no [so-]

Uh::::hm what could it still [so]

23 Physio [Lü]pfe isch das so [irgen-]

[Li]ft is this so [some-]

To lift is this some-

24 Patient [Eifa]cht ume- wenni <u>i</u>rgend anere=

[MOD] around- when I <u>a</u>ny at a=

***Eifacht* when I do something**

25 =Maschine so irgendöppis unkontrolliert mache u- wie en blödi Bewegig mache=

=machine so something uncontrolled make and- like a stupid movement make=

uncontrolled at a machine and- to make like a stupid movement

26 =das (.) git's jo mengisch [oder]

=this (.) happens PART sometimes [huh]

then this happens *jo* sometimes doesn't it

27 Physio [Im] stoh oder isch das grüpelet am Bode

[In] standing or is it crouched on the floor

While standing or is it while crouching on the floor

28 (0.8)

29 Patient Ja grupe chani sowieso nüme recht ir[gendw]ie (.) auso ich ha scho (.) hüt (.)

PART crouching can I anyway not anymore right so[meho]w (.) so I have already (.) today (.)

***Ja* crouching I cannot do this properly anymore anyway so I have already today**

30 Physio [Ja]

[Yes}

31 Patient wenni (.) rechts muess de Schueh- aso jetze mitere Schnalle inetueh [hani Müeh]

if I (.) right must the shoe- PART now with a buckle do in [have I trouble]

if I have to put the shoe on the right side - *also* now with a buckle I have trouble

32 Physio [Ja]

[Yes}

33 Patient muess i fasch echli murkse [oder aso i gspüres] eifacht [oder]

must I nearly a bit struggle [or PART I feel it] MOD [huh]

I nearly have to struggle a bit or *also* I feel it *eifacht* huh

34 Physio [Ja aso das isch jo-] [Mhm]

[Yes PART this is PART-] [Mhm]

Yes *also* this is *jo-* Mhm

35 (0.4)

36 Physio .hh Schuhe anziehen das isch de vor allem rechts he [ja]

.hh shoes put on this is then mainly right huh [yes]

.hh to put on the shoes is then mainly on the right side huh yes

37 Patient **[Mhm]**

38 (1.7)

39 Physio S'lüpfe isch das scho vu- vu liechte Sache het das- het das [mit em Gwicht z'tue]

The lifting is this already of- of light things has this- has this [with the weight to do]

The lifting is it already with light things or has it- has it to do with the weight

40 Patient [S'lüpfe an und für sich]

[The lifting in and for itself]

The lifting by itself

41 (.) isch ned s'Problem oder vu de Chraft her

(.) is not the problem or from the force coming

is not a problem or from the strength

42 (0.2)

43 Physio Ja

Yes

44 Patient I gspüres eifacht wenn- wenn- wenni- (.) guet denn macht mers de si-

I feel it MOD when- when- when I- (.) good then make one then su-

I eifacht feel it when- when- when I- well then one makes it su-

45 wahrschienlich ebe no falsch oder (.) wemme denn wott entlaschte od[er]

probably PART still wrong or (.) when then would like discharge h[uh]

probably *ebe* still wrong or when one would like to reduce the weight huh

46 Physio [J]a

[Y]es

B20 PTc Rx1_23.22 / Initial sequence

1 Physio De macheder s'Walking eigentlich jetzt sitem Früehlig.

Then make you the walking actually now since the spring.

You are then actually doing the walking since this spring

2 Patient Ja.

Yes.

3 (1.5)

4 Patient Aso letscht Johr im Früehlig.

PART last year in spring.

***Aso* last year in spring.**

5 (0.3)

6 Physio Ah (.) 07

Oh (.) in 2007

7 Patient Ja.

Yes.

8 Physio Ah jo de macheders scho dütlich länger ned he [aso-]

Ah yes then make you it since clearly longer not huh [so-]

Oh yes then you haven't done it for quite a long time huh so-

9 Patient [Ja]

[Yes]

10 (0.4) ((*patient nodding*))

11 Physio .hh Angerhalb Johr.

.hh One-and-a-half year.

12 (0.4)

13 Physio **.hh ↑Mhm**

14 (0.6)

15 Physio **Okay**

16 (1.6) *((physiotherapist writes in chart))*

17 Physio ts .hhhhhh (.) Und (.) Eues:: Zi:::el ↑jetzt oder Eui Erwartig ad ↑Physiotherapie?

ts .hhhhhh (.) And (.) your:: go::al ↑now or your expectation for ↑physiotherapy?

18 (1.7) *((Physiotherapist looks at the chart until the end of the pause, then looks up))*

19 Patient Jo dass mer eifacht löst ↑irgend[wie] (.) >wenns de eifach- <

PART that me MOD loosen ↑some[how] (.) >if it does then MOD-<

***Jo* that it *eifach* loosens up again somehow (.) if it *eifach*-**

20 Physio **[↑Mhm]** *((Physiotherapist starts writing in chart))*

21 (1.7) *((Physiotherapist writes in chart))*

22 Patient dass es eifacher ↑wird

that it easier ↑will be

that it will become easier

23 (3.8) *((Physiotherapist writes in chart))*

24 Physio **↑Mhm**

25 (6.3) *((Physiotherapist writes in chart))*

26 Physio Bi wellne Aktivitäte stört Euch denn das Problem im Moment am meischte=

With which activities bothers you then the problem at the moment the most=

In what activities does the problem bother you the most this time

27 woder säged (0.6) das möchti wieder besser chönne mache?

that you say (0.6) that would like I again better could do?

about which you say (0.6) I would like to be able to do that better again?

28 Patient Eigentlich alls

Actually everything

29 Physio ↑Mhm Was wäred die drü Wichtigschte?

↑Mhm What would be the three most important?

Mhm What would be the three most important activities?

30 (1.0) *((Physiotherapist looks at patient))*

31 Patient Jo mol (.) dass i wieder richtig cha schtoh [und-]

PART once (.) that I again correctly could stand [and-]

***Jo* at first that I could stand correctly again and-**

32 Physio **[↑Mh]m** *((Physiotherapist starts writing in chart))*

33 (1.8) *((Physiotherapist writes in chart))*

34 Patient Eifacht allgemein ↑d'Bewegig

MOD in general ↑the movement

***Eifacht* generally the movement**

35 (0.2)

36 Physio ↑Mhm aso was zum Biespi[el?]

↑Mhm so what for exam[ple?] *((Physiotherapist looks at patient at the end of the turn))*

37 Patient [Eb]e dass do de Rügge wieder-

[PART] that here the back again-

***Ebe* that the back here**

38 (0.7)

39 Patient ich weiss oned beweglicher oder-

I know also not more flexible or-

I don't know either more flexible or-

40 Physio Genau [wo stört nech] wenn der was mached stört nech i Euem Alltag störts=

Exactly [where bothers it you] when you what do bothers it you in your everyday bothers it=

Exactly where does it bother you when you do what does it bother you during your day

41 Patient [Weicher oder-]

[Softer or-]

42 Physio =nech vor allem dass (.) d'Beweglichkeit nid so geit

=you especially that (.) the mobility not so goes

does it bother you especially that the mobility is not so good

43 Patient Jo guet bim Schaffe [bim] Autofahre bim- [phhh] (.) bim Putze eigentlich immer

PART good at work [while] car driving while [phhh] (.) while cleaning actually always

***Jo* alright at work while driving a car while phhh while cleaning actually always**

44 Physio **[Mhm]** **[Mhm]**

45 (1.2)

46 Physio ↑Mhm (.) Was sölli no näh sölli no s'Autofahre und s'Putze näh oder gits anderi-

↑Mhm (.) What should I s□ll take should I still the car driving and the cleaning take or is there other-

Mhm What should I take should I take the driving and the cleaning or is there anything

47 öppis anders wo no wichtiger wär

something else that still more important would be

else that would be more important

48 (1.0)

49 Physio vu Aktivitäte wo igschränkt si

of activities that restricted are

in terms of activities that are restricted

50 (0.3)

51 Patient Jo guet s'Laufe das ↑geit

PART good the walking it ↑goes

***Jo* alright walking goes all right**

52 (0.2)

53 Physio **↑Mhm**

54 (4.0)

55 Patient Jo eifacht der ↑Alltag ↑allgemein

PART MOD the ↑every day ↑general

***Jo eifacht* the day-to-day activities in general**

56 Physio Mhm mhm I probieres sochli wie feschtzlegge will es isch (.) .hh schwieriger

Mhm mhm I try a bit like to define because it is (.) .hh more difficult

Mhm mhm I am trying to define a bit because it is .hh more difficult

57 nächher z'verglieche wenns irgend alls [isch] als wemme mol- es git jo viel=

afterwards to compare if it any all [is] as if one PART- there are PART a lot of=

to compare afterwards if it is everything than if there are *mol*- there are *jo* a lot of

58 Patient **[Mhm]**

59 Physio =Sache das [heisst jo ned] dasses denn nume die drü si aber das isch denn=

=things that [mean PART not] that it then only the three are but this is then=

things that *jo* does not mean that there are only those three but it is then like

60 Patient [Ja]

[Yes]

61 Physio =so wie womes denn so chli cha feschtma[che und] drum frogeni echli- (.) .hh

=like when one then so a bit can defi[ne and] that's why ask I you a bit (.) .hh

when one can define it a bit and that's the reason I ask you to define it a bit .hh

62 Patient [Ja]

[Yes]

63 Physio denn müesseds echli Indikatore si wo- won Euch wichtig si [oder es git jo]=

then must there a bit indicators be that- that you important are [or there are PART]=

then there have to be indicators that- that are important for you or there are *jo*

64 Patient **[Mhm]**

65 Physio =sicher ↑viel aber die einte sind echli wichtiger und die andere [echli weni]ger wichtig

=certainly ↑many but the ones are a bit more important and the others [a bit le]ss important

66 Patient [Ja]

[Yes]

67 (1.3)

68 Patient Jo guet ebe i dem Moment ↑s'Putze

PART good PART in this moment ↑the cleaning

***Jo* alright *ebe* in this case the cleaning**

69 Physio **↑Mhm**

70 (7.8) *((Physiotherapist writes in chart))*

71 Patient Da isch ↑schwär

This is ↑heavy

That is difficult

72 (0.3)

73 Physio S'Autofahre hender vori no [gnennt]

The car driving have you before also [said]

You mentioned also the driving before

74 Patient [S'Autofahre isch] no [ja]

[The car driving is] also [yes]

Driving a car also yes

75 Physio [↑Mhm] sölli mol das neh

[↑Mhm] should I PART this take

Mhm should I *mol* take this one

76 Patient Jo jo

Yes yes

77 Physio Aso wüsster wemmer de im Verlauf merked dass isch eh- ned so wichtig es isch=

So know you if we then in the course realize that is eh- not so important it is=

So you know if we then realize during the course that it is eh- not so important

78 =öppis anders wos nech eigentlich [fascht no meh] stört de wechslemer de das=

=something other that it you actually [nearly still more] bothers then change we then this=

that there is something else that is actually bothering you more then we change it

79 Patient **[Mhm]**

80 Physio =isch ned in .hh Stein gemeisselt und de wetti gern wüsse wie guet dass es ↑geit

=is not in .hh stone carved and then would I like to know how good that it ↑goes

this is not something carved in stone and then I would like to know how well it goes

G02 PTn Rx1_00.18

1 Physio Wieso siet Ihr do.

Why are you here.

2 (0.4)

3 Patient Wie bitte?

How please?

Pardon?

4 Physio Wieso siet Ihr do (.) was möchted Ihr gern.

Why are you here (.) what would you like.

5 (0.2)

6 Patient Na ich möchte- ja ich möchte mich gern bhandeln lassen

PART I would like- yes I would me like to treat let

***Na* I would like- yes I would like to be treated**

7 Physio >Bitte?<

>Please?<

>Pardon?<

8 Patient Ich möchte mich gerne behandlen lass[en]

I would me like to treat le[t]

I would like to be treated

9 Physio [↑Ja] (.) und was ist das Ziel.

[↑Yes] (.) and what is the goal.

10 (0.9)

11 Patient Dass ich wieder voll arbeiten gehen kann

That I again fully work go can

That I can go back to work fully

12 (0.6 – *therapist looks down to chart, turns it and prepares to start writing)*

13 Physio Das isch es schöns Ziel

That is a nice goal

This is a good goal

14 Patient Ja

Yes

G05 PTk Rx1_13.36

1 Patient Ich mache relativ viel (.) [süsch] mitem Hung go laufe tägl[ich] (.) süsch.

I do relatively a lot (.) [othertimes] with the dog go walking dai[ly] (.) othertimes.

I do quite a lot (.) othertimes I go walking with the dog daily othertimes.

((Patient looks at the chart while the physiotherapist is writing, then looks at window, then at husband))

2 Physio [Ja] [Ja]

[Yes] **[Yes]**

3 Husband Süsch

Othertimes

4 Patient **[hehehe]**

5 Physio [hehehe] (.) Okay (.) guet.

[hehehe] (.) Okay (.) good. *((Physiotherapist writes in his chart))*

6 (1.0)

7 Physio Ehh- ↑mhm

Uhh- ↑mhm

8 (1.0)

9 Physio Genau hh

Exactly hh *((Physiotherapist turns his gaze to patient))*

10 De hani no en (.) letzte ↑Frag was- was erwarte (.) sie (.) vu de Physiothera↑pie

Then have I still a (.) last ↑ques□on what- what expect (.) you (.) from the physiother↑apy

Then I have just one last question what- what do you expect from physiotherapy?

11 °was erwarte sie vu ↑mir°

°what expect you from ↑me°

what do you expect from me?

12 Patient °Ehm °

°Uhm ° (*((patient looks away and down to her foot))*

13 (2.4)

14 Patient Jo i wetti gern- aso i denke weni s'chneu denn würklich wieder chan mache das isch scho viel

PART I would like- PART I think if I the knee then really again can make that is already a lot

***Jo* I would like- *also* I think if I could bend the knee again that would already be a lot**

15 (1.3) *((Physiotherapist continues to look at patient who looks at chart))*

16 Physio S'chnü mache ↑mhm

The knee make ↑mhm

To bend the knee mhm *((Physiotherapist turns to chart to write, but stops as patients laughs))*

17 Patient Und an und für sich wett ich scho hehe dass d(h)e- dass d(h)e (.)

And to and for it want I yet hehe that th(h)e- that th(h)e- (.)

And I would like as well hehe that th(h)e- that th(h)e-

18 s'ganze wieder guet chunnt [aber eh-]

the whole again good comes [but eh-]

the whole thing gets better again but eh-

19 Physio **[↑Mhm] ↑mhm**

20 Patient Jo.

Yes.

21 (1.0)

22 Physio Eifacht dass sie- [Hobbies- Hobbies- und so wieter eifacht wieder chöi mache]

MOD that you [hobbies- hobbies- et cetera MOD again could do]

***Eifacht* that you can *eifacht* do the hobbies- hobbies- etcetera again**

23 Husband [(Eifacht d'Beweglichkeit)]

[(*Eifacht* the mobility)]

24 Patient [D'Beweglichkeit Aso dass ich <u>das</u> wieder cha mache] (.)

[The mobility So that I <u>that</u> again can do] (.)

The mobility So that I can do that again

25 Patient jo das wetti scho gern

yes this would I like to

yes I would like to

26 Physio **Mhm. (.) mhm.**

27 (8.3) *((Physiotherapist writes in chart))*

28 Physio Okay (.) also (.) luegemer mol einisch? h.h.h (1.0) Guet

Okay (.) so (.) look we PART once? h.h.h (1.0) Good

Okay (.) so let's have *mol* a look? h.h.h (1.0) Good