Small acts, large workplace dilemmas – Nursing and compassion in interaction. A conversation analytic study.

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Abstract

High profile care failures within the UK, and the subsequent emergence of and emphasis on values-based healthcare in policy, have resulted in calls for compassion to be embedded throughout nursing practice. This attention on compassion has frequently been focused on the individual nurse, with policy suggesting that a nurse's compassion is exhibited within and during interaction with the patient. There is however, little clarity regarding how compassion should be defined or what compassionate interaction involves.

Much of the existing research focuses on the perceptions and experiences of patients and/or healthcare professionals, concluding that compassion is an internal trait or state, which is expressed through communication practices (e.g. eye contact to display listening). However, while either conclusion leads to a recognition of the importance of communication skills, these studies provide little specificity about how compassionate interaction can be recognised or reproduced. This thesis addresses this research gap, presenting a conversation analytic study investigating how compassion is enacted within nurse-patient interaction.

Fieldwork was undertaken on hospital wards in a large teaching hospital and a reablement unit. Here twenty-seven audio- and/or video-recordings of naturally occurring interaction between advanced clinical practitioners (ACPs) and older patients were collected. These recordings were analysed using conversation analysis, and analysis focuses on three interactional phenomena:– patient problem-tellings; patient complaints; and ACP responses when there are problems hearing or understanding a patient's talk.

The analysis identifies interactional practices nurses use to acknowledge suffering and display compassion, within specific interactional contexts. However, the findings also show that contemporary conceptualisations of compassion sometimes present nurses with interactional and institutional dilemmas, which are little acknowledged in contemporary policy and research.

These dilemmas include the need to prioritise safe, effective long term care, which may alleviate greater suffering, over short-term responses that contemporary policy and research assume to be compassionate. Explicating the nuanced, micro-level interactional practices nurses use in such situations shows the sophisticated skill set nurses deploy to balance institutional and interactional needs in a complex care context.

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right time, and the random motivational words that would arrive through the door at just the right time.

Abbreviations

A&E	Accident and Emergency
ACP	Advanced Clinical Practitioner
AHP	Allied Health Professional
DPIA	Data Protection Impact Assessment
GCP	Good Clinical Practice
GDPR	General Data Protection Regulation
GP	General Practitioner
HCOP	Healthcare of the Older Person/s
ICU	Intensive Care Unit
MeSH	Medical Subject Heading
NHS	National Health Service
NIHR	National Institute for Health and Care Research
NMC	Nursing and Midwifery Council
PIS	Patient Information Sheet
PIE	Person, Interactions and Environment Observational Tool
PPI	Public Patient Involvement
REC	Research Ethics Committee
UoN	University of Nottingham

Table of Contents

Table of Figures

Table of Tables

Chapter 1 Introduction

The association between compassion and 'good' healthcare, particularly nursing, appears pervasive in the twenty-first century. Nurses are nominated for DAISY awards, which acknowledge "extraordinary compassionate care" (Daisy Foundation, 2022), nursing autobiographies are described as providing accounts of the "care, compassion and kindness" nurses provide (Watson, 2019, synopsis), and speaking at the 73rd National Health Service (NHS) birthday celebrations Sir Simon Stevens, the then NHS Chief Executive, stated:

"during COVID-19, NHS staff have once again shown their exceptional skill, dedication and compassion" (NHS England, 2021).

This association between compassion and 'good' healthcare is also evident in policy. Compassion is one of the NHS values listed in the NHS Constitution (Department of Health, 2015), and the NHS Long Term Plan (NHS England, 2019) states that "the highest levels of skill and compassion" (p.78) are required to work in the NHS. While all these statements suggest that compassion is synonymous with 'good' healthcare, or even 'good' healthcare professionals, they do not state what this compassion involves, or indeed clearly define compassion. There appears to be an implicit assumption that a shared, common-sense understanding exists about what compassion in healthcare entails.

Within healthcare, compassion has particularly been associated with nursing. The report into failings at the Mid-Staffordshire NHS Foundation Trust (Francis, 2013a) claimed that there was a tolerance of poor standards in nursing, and that nursing needed to "focus on a culture of compassion and caring" (p.76). A number of policy documents followed, which emphasised the development of this culture of compassion in nursing (Prime Minister's Commission on the Future of Nursing, 2010; Commissioning Board Chief Nursing Officer and DH Chief Nursing Adviser, 2012). The five-year strategy for nursing, Compassion in Practice (Commissioning Board Chief Nursing Officer and DH Chief Nursing Adviser, 2012) suggested there were six values and behaviours which underpinned nursing and could be used to help account for the services nurses provide: care, compassion, competence, communication, courage and commitment. Subsequent nursing strategies have reiterated that compassion is

the foundation of nursing (NHS England, 2016), and the Nursing and Midwifery Council (NMC) describes proficiencies such as effective communication, and accountability as necessary for compassionate, safe care (NMC, 2018a). There is however, still little explanation of what is meant by compassion or how it should be enacted. In fact, the implication embedded in Compassion in Practice (Commissioning Board Chief Nursing Officer and DH Chief Nursing Adviser, 2012) is that values such as compassion provide "an easily understood and consistent way to explain" and evaluate nursing services (p.13).

Recommendations that compassion should be taught (Department of Health, 2013), measured (Department of Health, 2008; Department of Health, 2013), and that evidence-based interventions needed to be developed to facilitate compassion in healthcare (Firth-Cozens and Cornwell, 2009; Department of Health, 2013) were all embedded in policy. Yet, teaching, measuring or developing interventions is problematic, if there is a lack of clarity regarding what exactly constitutes compassion or how it is enacted. The Creating Learning Environments for Compassionate Care project (Bridges *et al.*, 2018), which evaluated a ward based leadership programme aimed to develop team relationships and the delivery of compassionate care, included a systematic review of interventions for compassionate nursing care (Blomberg *et al.*, 2016). This review concluded that although some interventions warranted further evaluation, they could not recommend any of them at that time. Problems identified with the studies reviewed included not only methodological weaknesses but a lack of conceptual clarity. The prevalence of compassion as an espoused value throughout healthcare, particularly nursing, and the potential contradictions between concurrent calls to both measure and intervene to promote compassion, suggest further investigation of how compassion is enacted in practice is warranted. This thesis explores the enactment of compassion in the interaction between nurses and patients in hospital inpatient settings.

I begin in chapter two by reviewing the existing literature on conceptualisations of compassion in healthcare. The review is divided into three sections, and the first focuses on the theoretical debates over compassion in healthcare. The second and third sections focus on conceptualisations of compassion in healthcare policy and empirical research respectively. The review concludes

that there are ongoing debates regarding the conceptualisation of compassion in healthcare. Communication skills are however, regarded as a fundamental component of compassion, although there is little specificity about how to communicate with compassion. With limited evidence regarding how the communication skills identified as necessary components of compassion are enacted, the review concludes that any assessment of what compassionate interaction is comprised of needs to begin with the investigation of compassion within its interactional context.

To conclude the literature review, and develop a working definition of compassion for this study I outline commonly used definitions of compassion in the healthcare literature. As there are variations in conceptualisations of compassion, there are also variations in definitions of compassion. However, definitions commonly include an awareness and understanding of suffering, and the attempts taken to reduce or alleviate that suffering by the compassionate person. Based on these recurrent features, I adopt a definition of compassion which encompasses the acknowledgement of suffering and the observable actions that a nurse undertakes (in an attempt) to reduce or alleviate suffering.

Chapter three outlines the methodological approach adopted for the current research – conversation analysis. Having already noted the difficulties of deriving knowledge about the enactment of compassion from other qualitative approaches, which focus on what people say or think they do, or from quantitative measures, which make *a priori* claims about which components of an interaction comprise compassion, I justify the use of conversation analysis in the present research. I outline conversation analysis' theoretical foundations in Goffman's (1983) notion of the interaction order and Garfinkel's (1984) assertion that social scientists should study the methods people use to produce the social world and their understanding of it, showing how a conversation analytic approach can be used to expand current knowledge regarding the enactment of compassion within nurse-patient interaction.

In chapter four I outline the methods used to undertake a conversation analytic study in an in-patient hospital setting. This chapter includes the study design and rationale for the planning and collection of twenty-seven audio-visual

recordings of interaction between advanced clinical practitioners (ACPs) and older patients on healthcare of the older person (HCOP) wards and reablement units. The chapter then outlines the approach to transcription and analysis. Throughout, I address the ethical procedures and processes used to conduct the research and manage the data collected. As a nurse, with my own views about compassion and nursing practice, I also detail how reflexivity and ethnomethodological indifference were used to enhance the rigour of the research.

Chapters five to seven present the findings, with each chapter focusing on a different interactional phenomena. In chapter five, I focus on ACP responses to patients' problem talk. As hospital care generally involves interaction with people who have presented with a clinical problem, problem-talk is an almost inevitable feature of the healthcare encounter. However, it is also a location where patients may display suffering and a compassionate response may be required. In this chapter I identify and outline a number of different ACP responses to patient problem-tellings, all of which display an acknowledgement of suffering. I introduce the idea that competing interactional and institutional demands may mean that these acknowledgements are not always explicit acknowledgements as was suggested by the literature review. In addition to showing that ACP responses are adapted to the interactional context, this chapter also explores the practical application of some current definitions of compassion. This exploration includes raising questions about the 'alleviation' of suffering in compassionate responses.

Building from chapter five, chapter six explores ACP interactional responses to patient complaints about transgressions both by the ACP and third parties. Patient complaints are again an action which displays potential suffering, and ACPs use a variety of responses to acknowledge the patient's suffering. However, I present a number of cases where ACPs appear to avoid or mitigate their acknowledgement of patient suffering, in response to complaints that refer to a third party. I explore why ACPs may not acknowledge a patient's suffering in these situations, suggesting that there may be good institutional reasons not to affiliate with third party complaints. In some interactions, ACPs may need to navigate long-term prevention of suffering versus short-term compassionate responses.

The final analysis chapter focuses on ACP repair initiation during patient talk. Repair initiation occurs where the ACP interrupts the ongoing sequence of talk, to deal with a problem of hearing, speech or understanding (Kitzinger, 2013). As other-initiated repair can expose issues regarding a speaker's competency, there is the potential for such repair to cause embarrassment and patient suffering. This chapter shows how even the most 'common sense' recommendations regarding compassionate communication, such as listen or show attentiveness, may not always be possible, in a context where ACPs are constantly managing competing interactional and institutional demands. I suggest that some of the practices ACPs use to manage these unseen competing demands, are both small yet incredibly important acts. Lastly, I return to previous conceptualisations of compassion and question the implied dichotomy between compassion and uncompassionate care, suggesting that in everyday healthcare interaction a sharp distinction between compassionate and uncompassionate talk is both unhelpful and inaccurate.

In the final chapter, I discuss how these empirical findings contribute to our theoretical understanding and conceptualisation of compassion in healthcare, particularly nursing. In addition, I discuss the potential application of the findings to communication skills training, and to wider debates about the work that nurses do.

Chapter 2 Literature Review

2.1 Introduction

The focus of this study is the enactment of compassion within the interaction between older patients and advanced clinical practitioners (ACPs). In order to investigate compassion within its interactional context, the literature review aims to explore how compassion is conceptualised in healthcare, with a particular focus on compassion in nurse-patient interaction. The literature review focuses on three areas. Firstly, theoretical perspectives on compassion in healthcare are reviewed. Many of these theoretical papers' foundations are in philosophical literature on compassion. This means that a consideration of theoretical aspects of reason, values and meaning is relevant to discussions regarding conceptualisations of compassion. Secondly, exploration of the construction of compassion within policy is important. With the rise of values-based policy, use of the term compassion has increased, and healthcare professionals/organisations are responsible for implementing this policy. Finally, using a systemised search strategy, there is a review of empirical research which aims to conceptualise compassion, usually from the perspective of healthcare professionals or patients. As part of this review, research developing or using scales to measure compassion are also presented.

2.2 Theoretical perspectives on compassion in healthcare

Theoretical and philosophical debates regarding compassion in healthcare are addressed first in this review, because they often pre-date policy and empirical research on the subject. The theoretical papers reviewed derive from a systematic approach to searching the literature (see Appendix 1 and Appendix 2), however, as these papers incorporate debates in philosophy and psychology, references have been reviewed and wider papers included in an iterative process. As a result, three theoretical perspectives are presented: compassion as a virtue, compassion as affect and compassion as a rational process.

2.2.1 Compassion as a moral virtue in healthcare

The claim that compassion in healthcare, particularly in nursing, is a moral virtue originates in early discussion papers on the subject (Bradshaw, 2009; Schantz, 2007). von Dietze and Orb (2000) discuss compassion as a moral virtue, claiming that compassion involves "deliberate altruistic participation in another person's suffering" (p.168). While not rejecting the role of affect and rational thought in compassion, von Dietze and Orb (2000) claim these features are not what distinguish compassion. They suggest sympathy involves the feelings generated in an individual through witnessing suffering, while empathy is active. In empathy, the feelings generated by witnessing suffering result in deeper understanding. While affect and understanding may be conditions necessary for high quality care, von Dietze and Orb (2000) claim that it is the nurse's moral virtues and altruism that motivates them to participate in another person's suffering, and therefore provide care which addresses the patient's holistic needs. From this perspective, the moral virtues of the nurse are the essential component of compassion.

2.2.2 Compassion, affect and cognition

In addition to theoretical papers conceptualising compassion as a moral virtue, compassion has also been conceptualised as a psychological process, which requires affective and/or cognitive processes on the part of the healthcare professional (van der Cingel, 2009). As Archer (2018) shows, altruism may not be adequate for displays of compassion. Instead, Archer (2018) foregrounds the affective elements of compassion, emphasising the necessity of 'fellow-feeling' in compassion. That is, the compassionate person shares the unpleasant feelings of the sufferer and cares about the other's suffering. This 'fellow-feeling' and care result in compassionate motivation to do what is morally right. In contrast to rational benevolence[1], Archer (2018) outlines how compassionate motivation is a superior force for compassionate action. Firstly, if the compassionate person shares in the sufferer's feelings there is less

[1] Kant, 1797 cited by Nussbaum (1986) proposes that rational benevolence facilitates action to reduce or alleviate suffering through a rational understanding of another's situation.

discrepancy between self-interest and motivation. That is, in order to reduce their own suffering, the compassionate person is motivated to act. Secondly, Archer (2018) claims that it is harder to ignore the suffering of another, if we experience their suffering. Experiencing the suffering of others ensures that we are motivated to act morally. Finally, compassionate motivation, as opposed to rational benevolence, assists the sufferer to come to terms with their pain and distress. In healthcare encounters, Archer (2018) suggests that this sharing of suffering may increase co-operation and trust between the patient and healthcare professional. While still focusing on compassion as something that is morally good, Archer's (2018) claims shift the focus. Rather than compassion being the result of altruism or rational benevolence, compassion is motivated by the feelings generated by observing suffering.

As with Archer's (2018) presentation of compassion, other philosophers have focused on compassion as an emotion. However, rather than focusing on the feelings which generate compassion, their focus is on compassion as a rational emotion that results from cognitive processes. Snow (1991) claims that compassion is a rational emotion based on our understanding that we are all vulnerable to suffering and misfortune. In addition to the compassionate person understanding that they could experience similar suffering, Nussbaum (1996) also proposes that compassion depends on beliefs that the suffering is serious, and that the person suffering is not to blame for their situation. These three beliefs are what Nussbaum (1996) claims encourages individuals to care about others' suffering. Questions about the necessity of these three beliefs for compassion have however, been raised (Cokelet, 2018; Weber, 2005). In relation to the belief that the person suffering is not to blame for their situation, for example, Ekstrom (2012) discusses how healthcare professionals may feel compassion for someone with a drug addiction, even though they may concurrently feel that the person is to some extent at fault for their situation. While questioning the beliefs proposed by Nussbaum (1996), Ekstrom (2012) does not reject the notion that compassion is a rational emotion, and instead suggests that compassion depends on an appraisal, which involves assessing whether another's situation is causing suffering or distress. Regardless of the nature of the beliefs necessary for compassion, and the role of virtues, affect and cognition in compassion, these theoretical debates show that compassion is a complex social phenomenon that will vary according to the context and the individuals involved in the encounter.

2.2.3 Compassion, empathy and sympathy

Within the theoretical literature regarding compassion, debate also emerges regarding the relationships and distinctions between compassion, empathy, and sympathy. As other commentators have suggested concepts such as compassion, empathy and sympathy lack clarity (Post *et al.*, 2014; Sinclair *et al.*, 2016b). However, for the purposes of this thesis, there is a need to briefly outline similarities and differences between the concepts.

Sympathy is generally associated with the individual's feelings towards another person's troubles or misfortunes (Schantz, 2007; Sinclair *et al.*, 2016b; von Dietze and Orb, 2000). The feelings which sympathy is comprised of do however, vary within the literature. von Dietze and Orb (2000) suggest these feelings are the same as those experienced by the person who has experienced the misfortune, and Schantz (2007) suggests that sympathy involves "kinship with another's feelings" (p.51). In comparison, other commentators focus less on the correspondence between the sufferer and sympathetic person's feelings. Gilbert (2010) claims that sympathy involves showing concern for the other, while Sinclair et al (2016b) describes sympathy as pity towards the other person's troubles. There is however, a consensus among these commentators that sympathy is a passive, subjective response oriented to the self (Sinclair *et al.*, 2016b; von Dietze and Orb, 2000).

Focusing on empathy, there is a general consensus that empathy involves a cognitive process, which involves understanding the feelings and experiences of the other person (Gilbert, 2010; Sinclair *et al.*, 2016b; von Dietze and Orb, 2000). However, there is variation in whether empathy involves an affective element. Gilbert (2010) claims the emotional response is sympathy and the use of imagination to understand how another may feel is empathy. In comparison, other commentators suggest that empathy involves both cognitive and affective empathy (Post *et al.*, 2014; Sinclair *et al.*, 2016b; von Dietze and Orb, 2000), with affective empathy occurring when the empathic person is emotionally attuned (Post *et al.*, 2014). There is also a recognition that while empathy is a state, empathy (and sympathy) also involve the ability to communicate that

understanding to the other (Post *et al.*, 2014). For the purposes of this thesis empathy is therefore defined as:

"the ability to perceive and reason, as well as the ability to communicate understanding of the other person's feelings and their attached meanings" (Reynolds and Scott, 2000, p.226)

Having already outlined that theorists and philosophers suggest that compassion involves an affective and a cognitive element, questions emerge about the role of empathy and sympathy in compassion, and the distinction between compassion, and empathy and sympathy. With regard to the relationship between sympathy, empathy and compassion, there are differences. Post (2014) et al, for example, implies that the concepts are separate, proposing that healthcare professionals provide routine, empathic or compassionate patient care. In comparison, Kanov et al (2004) suggests that compassion comprises three interrelated elements – noticing, feeling and responding to the person's suffering. In this theory, noticing involves either an emotional reaction or a cognitive recognition of the person's suffering, and the feeling component is described as similar to empathic concern. In this theory, sympathy and empathy are therefore seen as integral components of compassion. Despite these differences regarding whether sympathy, empathy and compassion occur along a continuum (Post *et al.*, 2014) or are part of an integrated system (Kanov *et al.*, 2004), theorists consistently claim that compassion's distinguishing features include the motivation, and actions taken to alleviate suffering (Gilbert, 2010; Kanov *et al.*, 2004; Schantz, 2007; Strauss *et al.*, 2016; von Dietze and Orb, 2000). If compassion involves some sort of action to alleviate suffering, compassion must therefore occur within the context of interaction.

2.3 Compassion in healthcare: emergence, re-emergence or constant?

Before discussing conceptualisations of compassion in recent policy, I will briefly focus on whether compassion is a new concept or something re-emphasised in twenty-first century healthcare. Within the nursing literature, including research and policy focusing on compassion, claims are made that compassion is an enduring feature of practice (Bradshaw, 2009; Bradshaw, 2011; Chambers and Ryder, 2009; Maben, Cornwell and Sweeney, 2009). Bradshaw (2011) claims that in Florence Nightingale's view, good nurses were people who possessed specific qualities including compassion. A similar perspective can be seen in the strategy for nursing, Compassion in Practice (Commissioning Board Chief Nursing Officer and DH Chief Nursing Adviser, 2012), which suggests that compassion is one of the enduring values of nursing. There is however, an alternative perspective, which suggests that compassion emerged as a new concept, or a significantly different concept, in twenty-first century healthcare policy. Pedersen and Roelsgaard Obling (2019) question the assumption that Florence Nightingale established compassion as both a fundamental characteristic of the 'good' nurse or the foundation of high quality care. Notes on Nursing (Nightingale, 1860) focuses on the tasks a skilled nurse should undertake, particularly the necessity for observation, and does not mention compassion or empathy (Pedersen and Roelsgaard Obling, 2019). Chaney (2020) suggests that, while nineteenth and early twentieth century writings about nursing did detail some characteristics of the 'good' nurse, including sympathy and tact, these characterisations vary significantly from current conceptualisations of the compassionate nurse. Sympathy was seen as a technique for managing the emotions of the patient, rather than a means of understanding an individual's needs. In fact, it was thought that too much sympathy could hinder caregiving. Chaney (2020) claims that the understanding of sympathy in the interwar years is not congruent with current conceptualisations of compassion. Instead, current conceptualisations of compassion emerge from the shift towards patient-centred care in the late 1980's and values-based healthcare policy post 2009 (Chaney, 2020; Pedersen and Roelsgaard Obling, 2019; Singleton and Mee, 2017). Given this evidence suggesting that the use of the term compassion has changed and, as will be

outlined below, the recent rise in usage of the term, the review of policy that follows focuses on recent policy, particularly that post-2009.

2.4 Policy

The focus on compassion in policy has occurred predominantly since 2009. The NHS Plan (2000) contains only one reference to compassion. This reference, in a summary about public consultation, refers to the public trusting and valuing the "dedication, expertise and compassion of staff" (p.136). The present review of policy is therefore limited to key UK public inquiries and policy published between 2009 and 2015[2]. Particular focus is given to the inquiry into failures at the Mid-Staffordshire NHS Trust (Francis, 2010; Francis, 2013a; Francis, 2013b) (hereafter referred to as the Francis Inquiry), as these reports are frequently associated with the current focus on compassion in healthcare (for example, see Bramley and Matiti, 2014; Durkin et al, 2021a; Straughair and Machin, 2021).

2.4.1 Inquiries and reports

The initial report into failures at the Mid-Staffordshire NHS Foundation Trust (Francis, 2010) repeatedly attributes inadequate care and patient suffering to a lack of compassion. In addition to patients not being bathed, fed or hydrated, witnesses associate a lack of compassion with not talking to, or engaging with patients, as the quote from the report below shows:

"I think the lack of compassion was so notable. Kind words, professional words really" (p.155)

What impact patient and families' use of the term 'lack of compassion' in the Francis Inquiry had on wider uptake of the term compassion in healthcare is uncertain. An association is however made in the report both between 'lack of compassion' and communication, and 'lack of compassion' and healthcare professionals' relationships with patients. The initial Francis Inquiry implies that

[2] Explicit references to compassion in policy are limited after 2015, and when raised it is described as a known which does not need addressing (for example, see NHS England, 2016).

compassion results from good communication and positive relationships with patients. The features of compassion are however, defined by their absence – not caring or a lack of kind words. There appears to be an underlying assumption that, as a human trait, compassion is easily understood and, as such, patients and professionals share a common-sense understanding about what compassion is. However, defining compassion by its absence does not support healthcare professionals in developing or delivering compassion.

Within the initial Francis Inquiry (2010), there is also an implicit association made between compassion and the attitudes and values of staff. The report's recommendations include the promotion of a good standard of care, which involves treating patients with "care, sympathy, patience and respect" (p.414). The construction of compassion as a professional value, reflected in the attitude of staff, is clearly expressed in the later public inquiry into failings at the Mid-Staffordshire NHS Trust (Francis, 2013a; Francis, 2013b). The second inquiry, which focused on organisational, structural and monitoring failings, rather than individual failings, made 290 recommendations. Many of these recommendations relate to healthcare and regulatory systems. However, the report's first recommendation is that common values need to be re-emphasised throughout the system, to ensure that patient's needs are prioritised. These values included care, compassion and commitment, and the emphasis on a culture of compassion was particularly evident in recommendations related to nursing. The inquiry stated that declining professionalism was evident in nursing and recommended that:

"there should be an increased focus on a culture of compassion and caring in nurse recruitment, training and education." (p.76)

This culture of compassion would include the introduction of values-based recruitment and selection, and performance indicators. Essentially compassion is presented as a value or individual trait, which is embedded in the belief system of a 'good' nurse. Through recruiting staff with values such as compassion, patients would receive high-quality individualised care.

There are a number of critiques of the 'culture of compassion' proposed in the Francis Inquiry. While some critiques accept the construction of compassion as a fundamental value in nurses, they question the benefits of measuring

compassion. Bradshaw (2009) views compassion as a virtue necessary for nursing, and expresses concern that using proxy measures of compassion could mean that compassion is 'McDonaldised'. That is, people may act compassionately, without the essential quality of feeling compassion. For others the move to 'a culture of compassion' and 'meta-virtue management' (Pedersen and Roelsgaard Obling, 2019), obscures structural issues in healthcare (Chaney, 2020; Pedersen and Roelsgaard Obling, 2019; Smajdor, 2013). For example, there is increasing evidence that the number of registered nurses on a shift influences patient outcomes including mortality (Griffiths *et al.*, 2016; Rafferty *et al.*, 2007), and quality of care, which includes interactions (Ball *et al.*, 2016; Bridges *et al.*, 2019). As Smajdor (2013) states, compassion may be neither necessary or sufficient for the provision of quality healthcare. These critiques expose problems with constructing compassion as a value. Compassion becomes an ill-defined individual trait, to which good care is attributed. A lack of compassionate care is therefore also an individual failing, despite all the structural failings identified at Mid Staffordshire NHS Trust (Francis, 2010; Francis, 2013a).

In addition to the Francis Inquiry (2010; 2013a; 2013b), a number of other reports exploring compassion in healthcare (Firth-Cozens and Cornwell, 2009) and inquiries into failures in healthcare were published between 2009 and 2015 (Parliamentary and Health Service Ombudsman, 2011; Department of Health, 2012). While these inquiries do not explicitly recommend or promote compassion, they do conceptualise compassion implicitly. As with the Francis Inquiry, of the three philosophical ways of conceptualising compassion outlined in section 2.2, compassion as a moral virtue, which is exhibited in the attitudes and behaviours of staff, appears particularly influential in these reports. In the Parliamentary and Health Service Ombudsman (2011) investigation of ten complaints about the care of older people, for example, inadequate care, and the resulting patient suffering, are attributed to a lack of compassion in both professionals and institutions. While not explicitly defining compassion, the report suggests there is a discrepancy between the values outlined in the NHS Constitution (Department of Health, 2009), and the experiences of older hospitalised patients. Essentially, when healthcare professionals do not possess the appropriate values, the behaviours and attitudes of staff result in a lack of compassion. Similarly, the report into the care of people with learning disabilities at Winterbourne View recommends that recruitment and training

needs to ensure that staff have the right values and interpersonal skills (Department of Health, 2012). Throughout the inquiries into healthcare failures reviewed here, compassion is constructed either implicitly or explicitly as a value, which is exhibited within interaction. There is however, a lack of clarity regarding what exactly these interactional features are; instead, poor care is simply attributed to a lack of compassion.

2.4.2 National Policy

The call for compassion in healthcare is frequently attributed to the Francis Inquiry (for example, see Durkin et al, 2021a; Straughair et al, 2021), however, the introduction of values-based healthcare and recommendations regarding the measurement of values is actually evident in UK policy documents from 2007 (see Darzi, 2007). As Pederson and Roelsgaard (2019) suggest, this shift in policy towards values-based healthcare, may in part have been due to dissatisfaction and failures in new pubic management and market-based ideologies. These failures are clearly seen in the Government's response to the Francis Inquiry, which claimed that "targets and performance management" had prevented compassionate care (Department of Health, 2013, p.21). However, healthcare policy prior to this had recommended embedding values such as compassion into healthcare settings, in order to ensure personalised care (Department of Health, 2008), 'holistic wellbeing' (Prime Minister's Commission on the Future of Nursing, 2010) and patient satisfaction. As the quote below implies patients' satisfaction with their healthcare is linked to the provision of compassion:-

"Quality of care includes quality of caring. This means how personal care is – the compassion, dignity and respect with which patients are treated. It can only be improved by analysing and understanding patient satisfaction with their own experiences." (Department of Health, 2008, p.47)

As with the inquiries already discussed, these policy conceptualise compassion as a value, which is identified retrospectively based on a patient's care experience.

While policy recommends that values such as compassion need to be integrated within organisations, the features of these values are frequently associated with the behaviours and characteristics of individual healthcare practitioners. As

Table 2.1 shows compassion is defined in national policy using a number of different characteristics and behaviours including 'intelligent kindness' (Commissioning Board Chief Nursing Officer and DH Chief Nursing Adviser, 2012) and 'kindness and humanity' (Department of Health, 2015). Where policy does suggest that specific actions such as talking and listening display compassion, the behaviours of the healthcare professional appear to underpin these actions (Department of Health, 2008). The healthcare professional who talks and listens 'finds time', staff who understand 'make the effort', and 'doing the small things' is because the individual cares. This decontextualized focus on an overarching compassionate practitioner becomes problematic for a number of reasons. Firstly, the assumption that compassion can guide all roles and work is questionable (Pedersen and Roelsgaard Obling, 2019). There may be times when a compassionate response is not required or necessary. As Bloom (2018) questions – is it necessary for a surgeon to empathise with a patient as they perform surgery? Additionally, the 'small' or 'kind' action may be to leave a tired, critically ill patient to sleep overnight, however, medication or observations may prevent suffering and deterioration[3]. Secondly, compassion becomes solely the remit of the healthcare professional in a vacuum. Policy does not consider actions by the patient that necessitate a response, or the patient's circumstances. For example, a patient who is tired and unwell may not want to talk.

[3] This example does not deny that how waking a patient at night occurs, could influence the patient's perception of being woken.

Table 2.1 Uses and definitions of compassion in policy

Policy	Type	Purpose	Definition of compassion
High Quality Care For All (Department of Health, 2008)	Review of NHS services commissioned by Government.	Improving the quality of care patients receive.	"We find the time to listen and talk when it is needed, make the effort to understand, and get on and do the small things that mean so much – not because we are asked to but because we care."
Frontline Care (Prime Minister's Commission on the Future of Nursing, 2010)	Government Commission report and recommendations.	Exploring how nurses could implement High Quality Care For All and providing recommendations.	Not explicitly defined. States the public want caring and compassionate nurses who spend time with them and focus on their physical, psychological and emotional health.

Compassion in Practice (Commissioning Board Chief Nursing Officer and DH Chief Nursing Adviser, 2012)	Vision for nursing by Chief Nurse.	Strategy for Nursing building on the NHS Constitution.	"how care is given through relationships based on empathy, respect and dignity – it can also be described as intelligent kindness, and is central to how people perceive their care." (p.13)
The NHS Constitution (Department of Health, 2015)	Guidance.	Establishes the values underpinning the NHS.	"central to the care we provide and respond with humanity and kindness to each person's pain, distress, anxiety or need. We search for the things we can do, however small, to give comfort and relieve suffering. We find time for patients …. We do not wait to be asked because we care."
The Code (NMC, 2015)	Professional standards for nurses and midwives.	Standards Registered Nurses and Midwives must uphold.	Compassion not defined. Compassion regarded as part of treating patients as individuals and responding to those who are anxious or in distress.

Although compassion in policy is presented as a unifying value, in fact the characteristics and behaviours representing compassion vary between policies (Table 2.1). These differences create difficulties in clarifying how compassion is exhibited and how evaluation should proceed. This lack of clarity is further exacerbated by the non-specific language policy uses to define compassion. The assumption embedded within policy is that features such as "intelligent kindness" (Commissioning Board Chief Nursing Officer and DH Chief Nursing Advisor, 2012, p.13) and "the small things" (Department of Health, 2008, p.70) are known and understandable. While 'small things' may be intended to include ideas such as giving someone a drink, holding someone's hand or explaining that they will be woken in the night for medication, this is not clear, and how 'small things' is interpreted and contextualised will vary. Yet, High Quality Care for All (Department of Health, 2008) suggests that compassion can be assessed by measuring patient satisfaction. If compassion is not clearly defined, questions arise as to how it can be measured using traditional patient satisfaction surveys. Rather than a clear definition of compassion, a circular definition results, which is based on whatever compassion is measured to be.

In addition to the features of compassion varying between policies, there are also contradictions in the relationship between compassion and technical competence. Compassion is frequently presented as critical to nursing care, with Frontline Care (Prime Minister's Commission on the Future of Nursing, 2010) suggesting that compassion and technical care cannot be separated. However, the language used to describe compassion minimises its significance, when compared to technical care. High Quality Care for All (Department of Health, 2008), for example, refers to 'the small things' and 'finding time'. These examples suggest that compassion is less important than 'the big things' (i.e. clinical care), and that time should be used in other ways first. Even when the language used in policy does not minimise compassion, it separates compassion from technical care. In Frontline Care (Prime Minister's Commission on the Future of Nursing, 2010), which states, "truly compassionate care is skilled (and) competent" (p.4), the policy separates education and competence from compassion and caring. The potential result of these contradictions is that the importance of compassion is minimised:- technical care comes first. However, the concurrent assumption embedded in policy that compassion and competence work in harmony creates potential dilemmas for healthcare professionals. A healthcare professional may show technical competence, but if a patient is not

satisfied with care, a lack of compassion may be attributed to the healthcare professional. Returning to the example of waking a critically ill patient at night for observations, the observations may have prevented deterioration, but the patient may view the care as causing suffering because their sleep was disturbed. Essentially, delivering patient satisfaction becomes the responsibility of the individual healthcare practitioner and once again the influence of other structural factors is minimised (Chaney, 2020; Pedersen and Roelsgaard Obling, 2019; Smajdor, 2013; Traynor, 2017).

Contradictions in policy are not only evident in the simultaneous emphasis on the importance of compassion and concurrent minimising of compassion in relation to technical care. Compassion is also described in policy as something both innate and acquired. In Compassion in Practice (Commissioning Board Chief Nursing Officer and DH Chief Nursing Adviser, 2012), for example, compassion is described as both an existing value, which motivates people to enter nursing, and as something that can be taught and measured. The former suggests that compassion is an unchanging, innate feature of the individual. Yet, Compassion in Practice (Commissioning Board Chief Nursing Officer and DH Chief Nursing Adviser, 2012) discusses how the Department of Health (DH) will work with employers to improve skills, and how commissioning boards will explore measuring compassion. While measuring an individual's compassion may be possible, if compassion is an 'enduring value' both ongoing measurement and training in compassion would be unnecessary (Bradshaw, 2009).

This review of inquiries and policy shows that conceptualisations of compassion in policy are vague and contradictory. Nevertheless, of the philosophical perspectives outlined in section 2.2 the underlying assumption in both policy and inquiries appears to be that compassion is a moral virtue or value the healthcare professional possesses. Displaying this value is presumed to result in patient satisfaction, while dissatisfaction results from the healthcare professional's lack of compassion. Not only does the policy discourse ignore structural factors which are likely to influence patient satisfaction, there is a lack of specificity as to the actions compassion is supposed to encompass. Compassion is recognised in its absence through uncompassionate care, but in its presence only through vague actions such as 'talking', 'listening' and 'the

small things'. These actions ignore the context in which episodes of care occur, as well as the patient's involvement within these care episodes. Yet, there are recommendations in policy that healthcare professional's compassion needs measuring, and that training in compassion should occur (Commissioning Board Chief Nursing Officer and DH Chief Nursing Adviser, 2012; Department of Health, 2008)

2.5 Review of healthcare research on compassion

In the third part of this literature review, I will explore how compassion is conceptualised in healthcare practice, particularly nursing. While a scoping review by Sinclair et al (2016b) had explored compassion in healthcare, there had been a significant increase in research on the subject, since their search in 2014. A systematic review had also been published by Durkin et al (2018), however, this review focused on the qualities of compassion rather than its conceptualisation[4]. In order to explore conceptualisations of compassion and its enactment in healthcare, a scoping review was therefore undertaken. Scoping reviews are an appropriate method for clarifying the characteristics of a concept and identifying knowledge gaps (Peters *et al.*, 2020). While not appraising the quality of individual research papers, scoping reviews provide a broader mapping of the state of knowledge in a current area (Arksey and O'Malley, 2005). Recommendations for undertaking scoping reviews also mean that they offer "a rigorous and transparent method" (Arksey & O'Malley, 2005) for collecting and mapping research in an area. Prior to outlining how compassion is conceptualised in healthcare research, the methods for conducting the search and a summary of results are presented.

[4] Both the systematic review by Durkin et al (2018) and a number of other systematic reviews published while completing this review (see Durkin, Usher and Jackson, 2019; Singh et al, 2018, Tehranineshat et al, 2019a) are included within the scoping review.

2.5.1 Scoping review methods

The scoping review aims to outline knowledge regarding conceptualisations of compassion in healthcare practice. A secondary aim is to detail knowledge regarding the enactment of compassion in healthcare practice. To achieve these aims the inclusion strategy for this study encompassed:

1. Population – patients.[5]
2. Concept – compassion.
3. Context – nursing/healthcare practice.
4. Type of studies included - empirical research addressing the conceptualisation of compassion in healthcare or studies measuring compassion.
5. English language papers.

To develop the search strategy, keywords and synonyms relating to the population, concept and context were identified (see Appendix 1). Not all synonyms were included in the final search, as the search strategy needed to manage both comprehensibility and manageability. Empathy, for example, is a synonym of compassion, and preliminary searching had identified that compassion is indexed under the Medical Subject Heading (MeSH) 'empathy' in Medline. However, empathy was not included as a search term in the present search. As already discussed (section 2.2.3), while empathy may be a component of compassion, in this thesis they are considered distinct concepts. Preliminary searching including empathy also generated an unmanageable number of references for screening, most of which appeared to focus on empathy not compassion.

Subject heading and keyword searches for each component of the search were undertaken on CINAHL, Medline, Embase, PsychINFO and Amed (see Appendix 2 for Medline search). Searching multiple databases is a means of ensuring that

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[5] Only the patient population was used in the search strategy, as combining patient and nurse using the Boolean operator 'OR' created an unmanageable number of references. That the population includes healthcare professionals is also self-evident within the context used for the search i.e. nursing/healthcare practice.

the search strategy is comprehensive (Methley *et al.*, 2014). Due to limitations of the search strategy, and the indexing of studies relating to compassion and healthcare, review of the reference lists of selected studies was also undertaken to identify studies which may not have been identified in the database searches. Ideally, to ensure comprehensibility of the search, separate searches for 'compassion and healthcare', and 'compassion and patients' would have been undertaken. Prior to the formal searches, preliminary searching identified that some studies indexed their study under either patients or terms such as healthcare practice/nursing care. Combining the population and context meant the search strategy may have missed relevant studies. However, the number of studies identified through using 'compassion and patient', and 'compassion and healthcare' generated an unmanageable number of studies, within the time limits of a PhD study. Searching the reference lists of selected studies aimed to overcome this limitation.

Database searches identified 7349 records for screening, following removal of duplicates (see Appendix 3 for PRISMA flow diagram (Page *et al.*, 2021)). A total of seventy studies from the database search were included in the final review. Excluded papers included discussion papers, letters and commentaries, papers focusing on different concepts, e.g. compassion fatigue or compassionate leadership, and intervention studies which aimed to improve compassion in healthcare, unless they also specifically addressed conceptualisations of compassion or measured compassion. Research where the primary focus of the research was not compassion were also excluded, for example, where compassion was used as a descriptor to interpret results (for example, see Fry et al, 2013; Torjuul et al, 2007). Review of the reference lists for selected studies identified another seven studies, which resulted in a total of seventy-seven studies included in the final scoping review.

2.5.2 Overview of studies included in the review

The review shows that researching compassion in healthcare is in its relative infancy. Only three papers were published before 2010 and fifty-seven of the papers reviewed were published since 2016. As Table 2.2 shows, studies which aimed to conceptualise or describe compassion, as well as studies which developed or used scales to measure compassion, were identified. Of the studies exploring the components of compassion, the majority focus on the

healthcare professionals' and patients' perceptions and experiences of compassion in healthcare (see Appendix 4 for details of these studies). Many of these were qualitative studies, utilising semi-structured interviews or focus groups. Other qualitative methods adopted included ethnography and corpus-informed discourse analysis of online comments. A number of studies also used quantitative surveys to elicit healthcare professionals' understanding of compassion. In addition, twelve scales were identified which measure compassion in healthcare professionals. These scales were reviewed to ascertain how they conceptualise compassion, rather than to assess whether health care professionals are/are not compassionate (see Appendix 5 for details of included measures of compassion).

Table 2.2 Characteristics of studies included in scoping review

	No.
Date of publication (n.77)	
Published before 2010	3
Published 2010-2015	17
Published 2016-2021	57
Location of study (n.73)*	
UK	23
Europe	6
North America	24
Asia	7
Australasia	8
International	5
Type of study: (n.77)	
Systematic review	4
Scale/measure	12
Survey	5
Qualitative:	
Interview/focus group (inc. secondary analysis)	39
Ethnographic	5
Mixed methods	3
Other	9

Table 2.2 continued overleaf

Table 2.2 Characteristics of studies included in scoping review
(continued)

Participants: (n.61)**	
Patients	9
Healthcare Professionals	11
Nurse	17
Doctor	1
Healthcare students	6
Public/unknown	1
Patients and healthcare professionals	15
Healthcare environment: (n.30)	
(where focus a specific area/speciality)	
Medical/surgical ward	3
Long-term conditions	6
Palliative care	10
Older people	3
Emergency department/intensive care unit (ICU)	2
Mental health	4
Radiography	2

- *Excludes systematic reviews (for summary of systematic reviews see Appendix 6)
- **Excludes systematic reviews and scales

Research into compassion in healthcare has been conducted in a variety of contexts, and these contexts appear to be expanding. As Table 2.2 above shows, studies included in the review had been conducted in a number of countries. Research into compassion had also been conducted in a variety of healthcare settings, although research around compassion in healthcare is particularly prevalent in palliative care settings. While research has predominantly focused on nurses or nursing students, a number of studies have focused more generally on healthcare professionals and studies are emerging which focus on other professionals, for example, radiographers.

2.6 Empirical research exploring or addressing the conceptualisation of compassion in healthcare

Review of empirical research, which conceptualises or describes compassion found a number of recurring, and at times competing conceptualisations of compassion. These conceptualisations, which will now be discussed in more detail (see Appendix 7 for summary), include compassion as a virtue or characteristic of the individual, compassion as a value of the healthcare professional, compassion as a state involving affect and cognition, compassion as individualised care, compassion as competent care and compassion as interaction/communication.

2.6.1 Characteristics, values and behaviours of the healthcare professional

Throughout systematic reviews (Durkin, Gurbutt and Carson, 2018; Durkin, Usher and Jackson, 2019) and research on compassion in healthcare, compassion is conceptualised as a characteristic of the healthcare professional (see Appendix 7 for a full list of these studies). In interviews with inpatients Bramley and Matiti (2014) conclude that patient participants regard compassion as a moral virtue, while former patients, healthcare students and academics identify the personality of the healthcare provider as a feature of compassion (Straughair, Clarke and Machin, 2019; Straughair and Machin, 2021). As Figure 2.1 below shows, there is also research which attempts to clarify what some of these characteristics of compassion are. Following interviews with palliative care patients, Sinclair et al (2016a) identify genuineness, love, honesty, openness, care, authenticity, understanding, tolerance, kindness and acceptance as characteristics of the compassionate healthcare professional. There are however, subtle differences in whether these characteristics are described as virtuous traits, values or behaviours. Sinclair et al (2016a; 2018a; 2018b) identify the virtuous character of the healthcare professional as the catalyst for compassionate care, and virtuous responses as the overarching theme in interviews with palliative care patients and staff. In comparison, Fernando et al (2018) describes similar characteristics - love, honesty, openness, care, kindness, acceptance, friendliness, sincerity, professionalism, responsiveness

and sincerity - as comprising compassion. However, in these interviews with palliative care patients, there is a lack of clarity regarding whether these features are characteristics or behaviours of the healthcare professional. Regardless of whether features such as these, and those outlined in Figure 2.1 are virtues or behaviours, they do not provide evidence of how compassion is actually communicated.

Closely related to research findings suggesting that compassion is a moral virtue, or characteristic of the healthcare professional, are findings that conceptualise compassion as a core professional value (Curtis, Horton and Smith, 2012; Durkin, Gurbutt and Carson, 2019; Perry, 2009; Su *et al.*, 2019). In interviews with healthcare staff working in rehabilitation, Burridge and Foster (2019) describe compassion as a moral value, which is distinguished from values such as efficiency by the treatment of patients with care, as opposed to the performance of tasks. Compassion is also conceptualised as an overarching moral value comprising other values. Following interviews with key stakeholders, Kneafsey et al (2016) include "altruistic values (particularly the desire to help others)" (p.74), in their definition of compassion. In other studies, compassion includes adherence to a number of other moral values including respecting the patient's rights to dignity, justice, privacy, patient autonomy and appropriate care (Taylor and Hodgson, 2020; Tehranineshat *et al.*, 2019b). While conceptualisations of compassion as a value occur predominantly in studies including healthcare professionals and students, in research exploring patients' perceptions and experiences of compassion themes such as being treated with respect and dignity have also been identified (Fernando *et al.*, 2018; Badger and Royse, 2012).

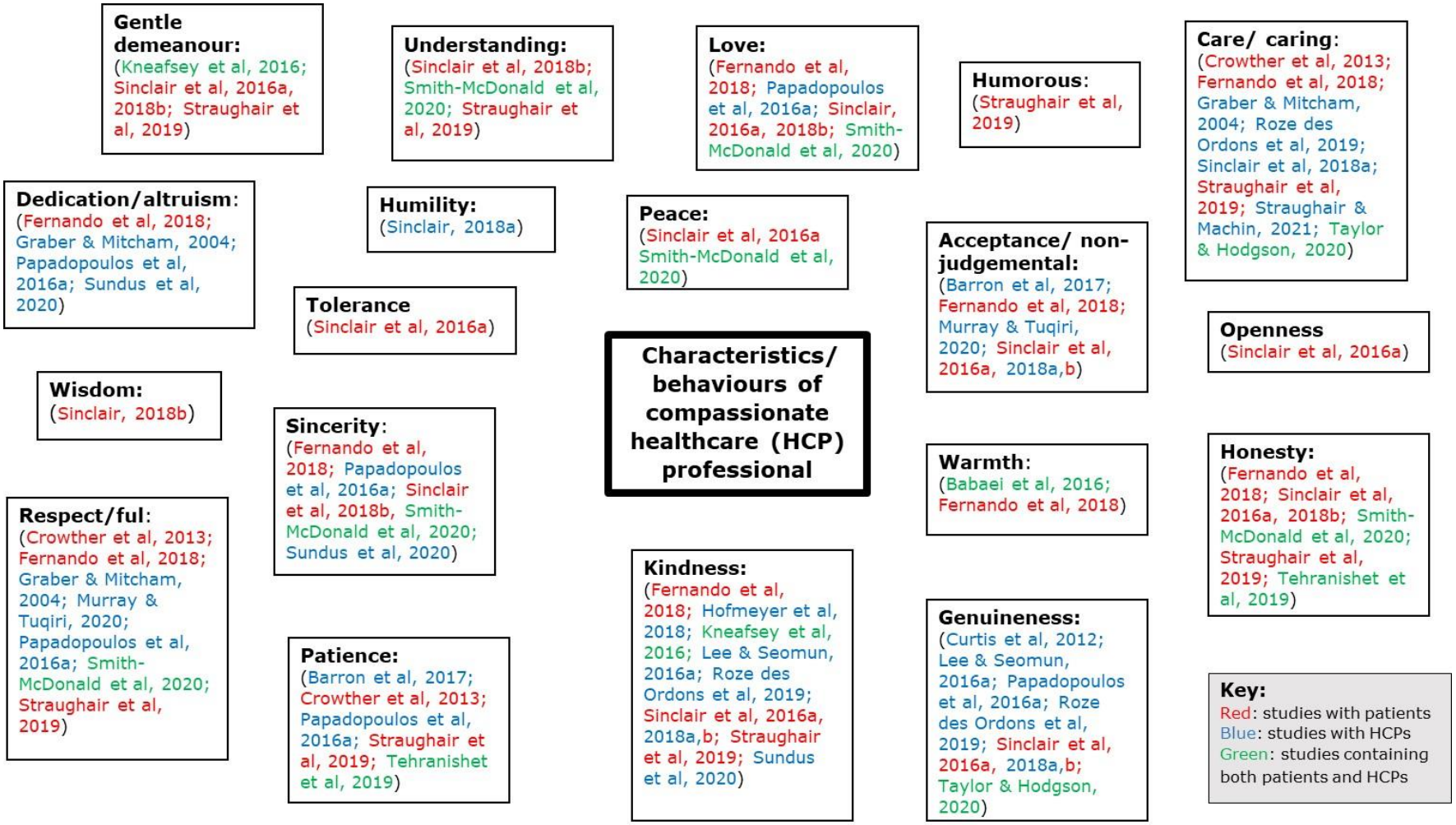


Figure 2.1 Characteristics and/or behaviours associated with compassion

These varying conceptualisations of compassion as a personality trait, value and/or behaviour inevitably result in differing perceptions on how it is attained. As Table 2.3 below shows, compassion is variously presented by healthcare professionals and patients as innate and/or acquired (Kneafsey et al., 2016, Papadopoulos et al., 2016, Tierney et al., 2017). In interviews with stakeholders in nursing education, Kneafsey et al. (2016) show that compassion is regarded by these stakeholders as both something that people are born with, and something that can be developed through education. Similarly, in a discourse analysis of online commentary in response to media reports that nursing students would be required to undertake care work prior to commencing training, Bond et al (2018) identify that compassion is conceptualised as both an innate trait and a behaviour which can be learnt.

The alternative interpretations of the features described in Figure 2.1 as either individual traits, values or behaviours has implications for training to improve compassion. Firstly, personality traits imply something internal, which is perhaps less amenable to change. In comparison, behaviours are influenced by external, structural factors as well as individual dispositions (Stroebe, 2011). If the features of compassion are regarded as behaviours or values they are therefore perhaps more subject to change and teaching. Professions such as nursing and medicine have their own values, which are embedded into codes of conduct (see for example NMC, 2015; General Medical Council, 2013), and a feature of training is to teach these professional values (for example, see NMC, 2018). Secondly, behaviours are directly visible. They are something participants see within interaction. Internal traits are only indirectly visible: while it cannot be known for certain that someone possesses a trait such as genuineness or sincerity, behaviours that characterise these traits can be observed.

Table 2.3 Quotes from research findings related to the notion of compassion as innate or acquired

	Participants	Compassion as innate	Compassion as acquired or learnt
Bramley and Matiti (2014)	Patients	Integral/brings people into nursing. "if they are not that way inclined you can't teach them." (p.2796)	Shaped through training and the environment. "I do not see why they cannot be taught." (p.2796)
Bond (2018)	Online discussants following report on proposal for healthcare experience prior to nurse training	Inherent attribute/innate personal trait. "The idea that you can teach compassion is nonsense. You can't teach people what is essentially an innate skill." (3087)	Learnt through training in interpersonal skills. "A good dose of hands on experience and compassion development."
Bray et al 2014	Health care professionals and students	"I don't think it can be taught, I think it's something that you have within yourself, you can be a compassionate person or …, I don't think you can really teach somebody how to be compassionate."	"Suppose you could, in one sense you could improve your social skills and your communication skills which could help you be more compassionate towards your patients."

Kneafsey et al. (2016)	Clinical staff, university health care staff, students or the public	"You have to have the basis of it when you're born with it and if you haven't got in you can't learn it." (p.74)	"You can increase it yeah." (p.74)
Papadopoulos et al. (2016)	Nurses (international)	25% respondents felt could not be taught.	59.6% respondents believed compassion could be taught.
Smith McDonald et al, 2019	Long-term care residents, family members, healthcare staff, managers	"It's innate" (p.6) "Compassion is just having it in your heart." (p.4)	"It can be enhanced for sure... I think with the right character you can teach compassion." (p.6)
Straughair et al 2019	Public with experience of nursing care	"compassion has to be in everybody doesn't it, you either have it or you don't." (p.1531)	"Well, I think the right training is vital." (p.1533)
Straughair et al 2021	Nursing students & nurse academics	Individual's intrinsic disposition. "some people are born slightly more caring than others." (p.47)	Education an essential starting point. "Education is key … compassion should actually be demonstrated in the classroom." (p.47)

2.6.2 The process of compassion: Feelings and understanding

In addition to research conceptualising compassion as a characteristic of individual healthcare professionals, other research suggests that compassion involves a process of empathy. Papadopoulos et al (2016b) noted in an international online survey of nurses, using pre-formulated questions, that while overall 59.5% of nurses defined compassion as a 'deep awareness of the suffering of others and a wish to alleviate it', in the UK the majority of participants defined compassion as 'empathy and kindness'. Similarly, in Bray et al's (2014) survey of healthcare professionals' and students' understanding of compassion, the most frequent response was acting with warmth, empathy and respect. While survey designers make *apriori* assumptions that empathy is a component of compassion, empathy is also a consistent theme in studies exploring healthcare professionals' and patients' perceptions, understanding and experiences of compassion (Babaei, Taleghani and Kayvanara, 2016; Badger and Royse, 2012; Bessen *et al.*, 2019; Bramley and Matiti, 2014; Curtis, Horton and Smith, 2012; Durkin, Gurbutt and Carson, 2019; Fernando *et al.*, 2018; Ferraz, O'Connor and Mazzucchelli, 2020; Horsburgh and Ross, 2013; Kneafsey *et al.*, 2016; Su *et al.*, 2019; Tierney *et al.*, 2017). As alluded to in relation to theoretical discussions regarding sympathy, empathy and compassion, there are however, differences in the importance attached to, and inter-relationship between, feelings and understanding.

In research exploring healthcare professionals' experiences and perceptions of compassion, feeling and understanding are described as facilitating compassion. There are however, differences regarding the sequence in which feelings and understanding occur, and the type of feelings and responses that result. In focus groups with key stakeholders, Kneafsey et al (2016) report that "gut feelings" encourage nurses to understand the patient. In comparison, healthcare professionals in other studies report that considering how they would feel in the sufferer's shoes generates feelings of concern or care (Straughair and Machin, 2021; Su *et al.*, 2019; Sundas *et al.*, 2020; Tierney *et al.*, 2017; van der Cingel, 2011). There are also variations in how the feelings generated, and subsequent responses by healthcare professionals are described. In some research, feeling what it must be like for the patient is described as resulting in

treating the patient as the healthcare professional would want to be treated (Burridge and Foster, 2019; Day, 2015; Horsburgh and Ross, 2013). Other research reports that the feelings generated in the healthcare professional, result in efforts to understand the patient's circumstances and display this understanding (Durkin, Gurbutt and Carson, 2019; Ferraz, O'Connor and Mazzucchelli, 2020; Kneafsey *et al.*, 2016; van der Cingel, 2011). In interviews with student nurses in the UK about socialisation in compassionate practice, Curtis et al (2012) quote one participant who states:

"I find when you put yourself in other peoples' shoes you understand them a lot more, even drug users…if I'd had their kind of life how do you know that that couldn't have been me…that is compassion." (p.792)

Similarly, in the action research project 'Leadership in Compassionate Care' nurses report that rather than treat patients as the nurse would want to be treated, they now took time to understand how the patient felt (Dewar and Mackay, 2010; Dewar and Nolan, 2013).

With regard to research exploring patients' perceptions and experiences of compassion, findings also suggest that compassionate action results from the feelings and understanding of the healthcare professional (Badger and Royse, 2012; Bramley and Matiti, 2014; Fernando *et al.*, 2018; Sinclair *et al.*, 2016a). The significance of feeling and understanding do however, again vary between studies. While in Bramley and Matiti's (2014) study participants wanted nurses to consider how they would feel in the patient's position, other studies emphasised that compassion involved nurses understanding the patient's suffering and feeling the same way as the patient (Fernando et al., 2018, Sinclair et al., 2016, van der Cingel, 2011). There were however, also differences between these studies and those exploring healthcare professionals' perceptions of compassion. In particular, the role of care or concern varied. In interviews with healthcare professionals, feelings and understanding are described as evoking care and concern for the patient (Devik, Enmarker and Hellzen, 2019; Sundas *et al.*, 2020). Expressed concern or, more specifically, expressions of sorrow or pity are however, classified as uncompassionate in research that focuses on patients' experiences and perceptions of compassion (Straughair, Clarke and Machin, 2019). Sinclair et al's (2017a) research, which explores palliative care patients' perspectives and understanding regarding sympathy, empathy and compassion, identifies sympathy as a shallow,

unhelpful emotion, which focuses on the healthcare professional's needs. The perspectives of patients and healthcare professionals may not however, be contradictory, and other research suggests that sympathy can be the catalyst for action to benefit the patient, as suggested by the quote below from secondary analysis exploring palliative home care nurses' experiences of delivering compassionate care in Norway.

"It did something to me … to see how lonely and lost she was, ate almost nothing. She was so shy, and did so little for herself …it just felt good to be there for her." (Devik et al, 2019, p.198)

Clearly there are differences in the role of feelings and understanding in conceptualisations of compassion in the research reviewed. However, there appears to be agreement that compassion is action-oriented, with patients wanting responses which display both emotional resonance and understanding (Babaei, Taleghani and Kayvanara, 2016; Ferraz, O'Connor and Mazzucchelli, 2020; Sinclair *et al.*, 2016c; Sinclair *et al.*, 2017a; Sinclair *et al.*, 2018a; Skorpen Tarberg *et al.*, 2020; Taylor and Hodgson, 2020; Taylor, Bleiker and Hodgson, 2021; Tehranineshat *et al.*, 2019b).

2.6.3 Individualised care and competent skilled care

The concept of individualised care is also one which recurs when research seeks the perspectives of patients and healthcare professionals. Sinclair et al (2016a) report that patients describe compassion as the healthcare professional seeking to understand the person and their needs. This seeking to understand the patient results in the healthcare professional attending to the patient's physical, emotional, spiritual, familial and financial needs. From this perspective, holistic, individualised care is therefore the/an outcome of compassion. But here again there is no consensus in the literature, other literature positions individualised and/or holistic care as a component of compassion (Bramley and Matiti, 2014; Badger and Royse, 2012; Graber and Mitcham, 2004). 'Humanising compassion', which involves treating the patient as an individual is the overarching theme in Straughair et al's (2019) analysis of patients' perceptions of compassion. Similarly, in both Sundas et al's (2020) interviews with student nurses, and Tehranineshat et al's (2019b) interviews with patients and healthcare professionals, conceptualisations of compassion incorporated meeting the individual patient's holistic needs.

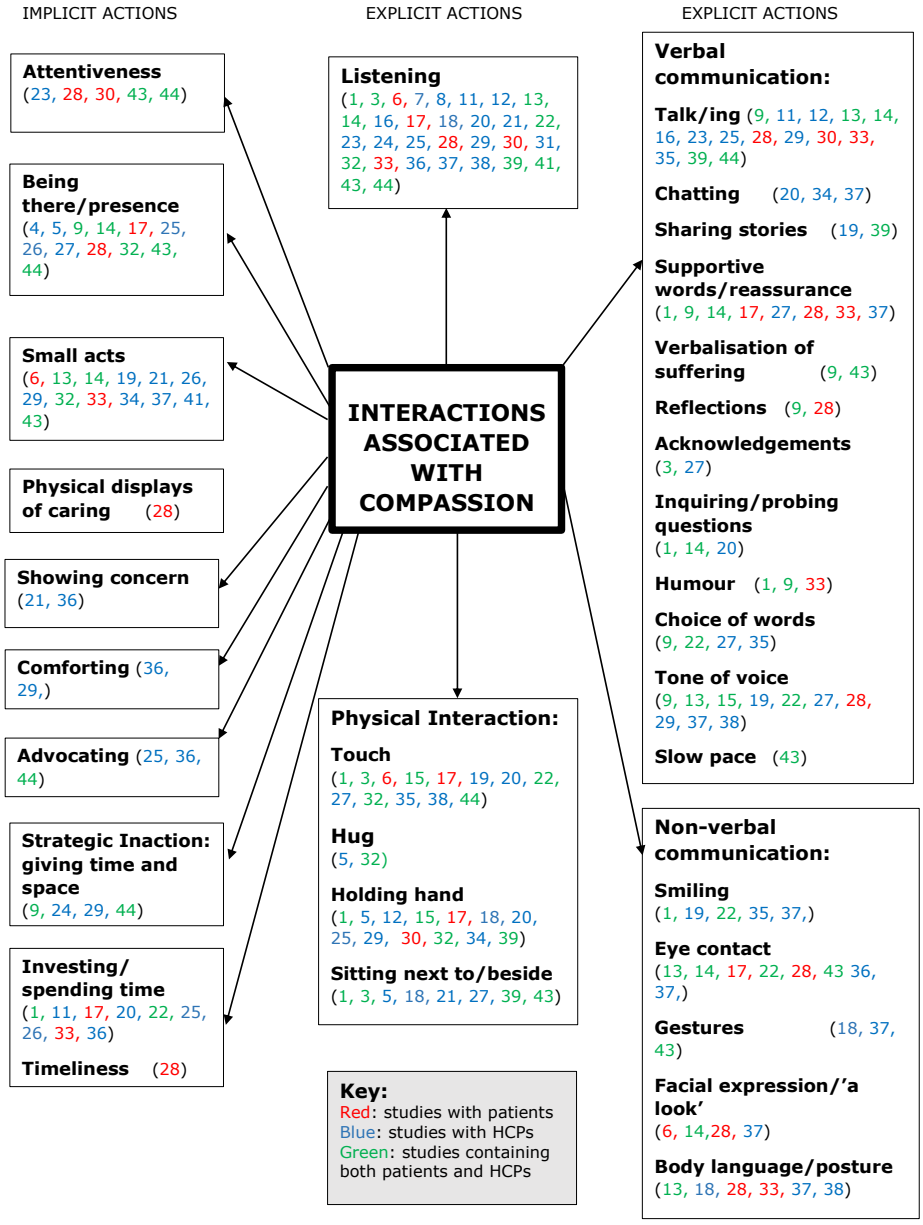
Regardless of whether individualised, holistic care is seen as a component or outcome of compassion, both elements are evident in research exploring healthcare professionals' and patients' perceptions and experiences of compassion. A task focus as opposed to an individual focus is seen to be one way in which a lack of compassion can arise (Burridge and Foster, 2019; Kneafsey *et al.*, 2016; Murray and Tuqiri, 2020; Nijboer and van der Cingel, 2019; Straughair and Machin, 2021). There is also evidence that practitioners feel that compassion also involves competent, skilful care (Durkin, Gurbutt and Carson, 2019; Tehranineshat *et al.*, 2019b). In interviews, nursing students identify following evidence and protocols as a component of compassionate care, which ensures patients are not subjected to additional suffering (Sundas *et al.*, 2020). Similarly, Sinclair et al (2018a) quote a healthcare professional who reports that they see completing discharge paperwork as a component of compassion, because completion ensures continuous care and reduces the risk of additional suffering. This finding extends beyond studies involving healthcare professionals, with the provision of competent care a theme identified following focus groups with individuals who had received treatment for complex burns (Badger and Royse, 2012). The research evidence therefore suggests that competent, proficient care is seen as a component of holistic care in terms of the enaction of compassion.

2.6.4 Compassion and interaction

Regardless of the position or importance attributed to the characteristics of the healthcare professional and/or their thoughts and feelings in conceptualisations of compassion, research consistently identifies communication as a critical element of compassion (see Appendix 7 for a full list of these studies). Kneafsey et al. (2016) identify "positive communication and consistency" (p.74) as a theme resulting from interviews with healthcare stakeholders, while van der Cingel (2011) concludes, from interviews with nurses and older patients with chronic diseases, that compassion is a process of "intuition and communication" (p.676). In fact, on the basis of ethnographic research in a hospice, Way and Tracy (2012) conclude that interaction is "the heart of compassion" (p.308). In conjunction with the identification of communication as an element of compassion, a variety of different interactional/communicative practices have been identified, which comprise compassion. As Figure 2.2 shows, some of

these are clear communicative actions such as touch, talk and smiling, while others such as attentiveness, presence and 'small acts' convey the notion of interaction implicitly.

Figure 2.2 Actions associated with compassion



1. Babaei et al., 2016
2. Badger & Royse, 2012
3. Baker et al., 2018
4. Barron et al., 2017
5. Bessen et al., 2019
6. Bramley & Matiti, 2014
7. Bray et al., 2014
8. Brown et al., 2014
9. Cameron et al., 2013
10. Crowther et al 2013
11. Curtis et al 2012
12. Day, 2015
13. Durkin et al., 2019
14. Durkin et al., 2021a
15. Durkin et al., 2021b
16. Efstathiou & Ives, 2018
17. Fernando et al., 2018
18. Ferraz et al., 2020
19. Graber & Mitcham, 2004
20. Hofmeyer et al., 2018
21. Hunter, 2018
22. Kneafsey et al., 2016
23. Lee & Seomun, 2016a
24. Murray & Tuqiri, 2020
25. Papadopoulos et al., 2017
26. Perry, 2009
27. Roze des Ordons et al., 2019
28. Sinclair et al., 2016a
29. Sinclair et al., 2018a
30. Sinclair et al., 2018b
31. Skorpen et al 2020
32. Smith McDonald et al., 2019
33. Straughair et al., 2019
34. Straughair & Machin, 2021
35. Su et al., 2020
36. Sundas et al., 2020
37. Taylor et al., 2021
38. Taylor & Hodgson, 2021
39. Tehranineshat et al., 2019b
40. Tierney et al., 2016
41. Tierney et al., 2017
42. Tierney et al., 2018
43. van der Cingel, 2011
44. Way & Tracy, 2012

There are however variations within the research reviewed about the position and framing of communication in relation to other components of compassion. In the collection of research conducted by Sinclair et al (2016a; 2018a; 2018b; Smith-MacDonald *et al.*, 2019), the moral virtues possessed by the healthcare professional manifest in compassionate action. In comparison, in Kneafsey et al's (2016) analysis of stakeholders' understanding of compassion, the feeling of compassion leads the nurse to act and display compassion. Enacted compassion is therefore seen to flow automatically from either virtues, feelings or understanding. While these studies list characteristics and/or behaviours which display compassion (Figure 2.1), and do suggest examples of compassionate communication (Figure 2.2), detailed discussion of how compassion could or should be done is largely absent. In comparison, on the basis of ethnographic research in a hospice, Way and Tracy (2012) conclude that while the feelings of the healthcare professional are important, they are not essential for compassionate action. Instead, they claim that communication which the provider or receiver regards as compassionate is crucial to compassionate care, even if the provider does not feel empathy. Even in Way and Tracy's (2012) research, which claims interaction is the core feature of compassion, the communication practices comprising compassion are framed as what participants perceive them to be.

While research that aims to conceptualise compassion consistently shows that compassion is embedded within communication, as Figure 2.2 shows, the practices associated with compassion vary between studies. Even where research identifies the same communicative practice, the framing of the practice varies. 'Talk' or 'talking' provides a good example of these variations. In some studies talk refers to 'having a chat' (Fernando *et al.*, 2018; Straughair and Machin, 2021) or 'chit chat' (Taylor, Bleiker and Hodgson, 2021), suggesting compassion is additional to routine care. Examples of talk also include apologising for possible discomfort (Taylor, Bleiker and Hodgson, 2021) and talking or explaining what is happening (Efstathiou and Ives, 2017; Su *et al.*, 2019; Badger and Royse, 2012), suggesting that compassion is a component of routine care. Research also identifies that there may be times where patients do not want to talk, and the compassionate action is to acknowledge and accept this (Taylor, Bleiker and Hodgson, 2021; Sinclair *et al.*, 2018a; Way and Tracy, 2012). Similarly, there are inconsistencies in when, and if the use of humour is compassionate, with some research suggesting that humour displays

compassion (Babaei, Taleghani and Kayvanara, 2016; Cameron *et al.*, 2015; Dewar and Nolan, 2013; Durkin, Gurbutt and Carson, 2019; Straughair, Clarke and Machin, 2019) and other research identifying times when the use of humour is both inappropriate and uncompassionate (Firth-Cozens and Cornwell, 2009). Both the wide variety of interactional practices associated with compassion, and lack of consistency, suggest that the enactment of compassion closely relates to the context. Interaction regarded as compassionate by one individual, may not be regarded as compassionate by another. Similarly, interaction regarded as compassionate in one context may not be regarded as compassionate in another. Some studies explicitly recognise this (Bessen *et al.*, 2019; Su *et al.*, 2019; Taylor, Bleiker and Hodgson, 2021); for example, as a medical student in Tierney et al's (2018) research reports:

"If you're being compassionate to someone, it might be very different being compassionate to person A and being compassionate to person B." (p.279)

However, there appears to be an absence of research explicating these variations further and exploring the actual enactment of compassion within its interactional context as opposed to hypothetical or post hoc reports of it.

2.6.5 Contextualising compassion – patient factors

The literature presented so far suggests that compassion is a response by the healthcare professional. The review has not yet explicitly considered the patient factors involved in compassion, although I briefly addressed the seriousness of suffering when discussing theoretical perspectives on compassion (see section 2.2). There are however, variations regarding the role of suffering in compassion, and the patient factors which are reported to initiate compassion in research exploring conceptualisations of compassion in healthcare. In some research, the issue of patient suffering is made explicit. Way and Tracy (2012) identified suffering as an overarching category of compassion, which included expressions of, and responses to compassion, when employing participant observation in a hospice. In comparison, in interviews with palliative care patients, Sinclair et al. (2016a) state that suffering was an implicit theme. Similarly, the quote below from interviews with hospital inpatients highlights how suffering may permeate responses, even when not explicitly discussed in a study:

"The person in the bed or chair is hurting, they're frightened, they're bewildered and perhaps never experienced being in hospital before". (Patient participant, Bramley & Matiti, 2014, p.2796)

While the quote above perhaps suggests that compassion is produced in response to serious suffering, there is also evidence that, in healthcare, the production of compassion is responsive to patient need. Older people and nurses, asked about suffering during interviews, associated suffering with everyday troubles and the loss of possibilities. In fact, van der Cingel (2011) notes that these troubles were not always framed as suffering but as limitations on daily activities and the associated distressing emotions. Similarly, when practitioners and patients give examples of compassionate responses, they appear to respond to patient need rather than serious suffering. Examples include keeping patients occupied to prevent boredom in acute mental health settings (Brown *et al.*, 2014), ascertaining the most comfortable position for a patient in radiography (Taylor, Bleiker and Hodgson, 2021) and, in long-term care, helping residents with needs such as washing and dressing (Perry, 2009). In these examples, compassion appears to respond to individual patient need. Following research exploring palliative care patients' understanding and experiences of compassion, Sinclair et al (2016a) propose that through attending to patient's physical, emotional, spiritual, familial, and financial needs healthcare professionals can alleviate suffering. Essentially, through responding to patient's needs suffering is reduced or alleviated. Patient need and suffering therefore appear to be almost synonymous in healthcare research exploring compassion, or at least there is an assumption that patient need is the cause of suffering. There appears to be minimal distinction of the relationship between the seriousness of suffering and need. Clearly, seriousness is subjective, and different patient needs may cause suffering depending on the patient and the context.

2.6.6 Empirical research addressing conceptualisations of compassion in healthcare: Issues of study design and assumptions

This review of research exploring conceptualisations of compassion, largely from the perspective of either patients or healthcare professionals, suggests that compassion is seen to comprise or contain a number of common features. Frequently identified components include the presence of patient need or suffering, the moral character of the healthcare professional, the healthcare professional's ability to feel and understand the situation, and finally the healthcare professional's response, which is observed within interaction. There are however, subtle differences in the construction of compassion, including which features dominate. That is, whether virtues, the healthcare professional's emotions, or interaction are the key element. Debates are also evident about whether compassion is innate or acquired, and whether specific practices, for example, humour, display compassion or a lack of compassion. The role of the research participant as either the giver or receiver of compassion may partly account for these differences. While patients, for example, report that they do not feel displays of sympathy including sadness and sorrow convey compassion (Sinclair *et al.*, 2017a; Straughair, Clarke and Machin, 2019), healthcare professionals report that feelings of concern and sadness motivate care and compassion (Devik, Enmarker and Hellzen, 2019). As discussed earlier, the two perspectives are not mutually exclusive; however, there are a number of issues with the design and underlying assumptions of the studies reviewed, which mean they are of limited relevance in understanding the enactment of compassion within nurse-patient interaction.

In addition to the position of the interviewee as giver or receiver of compassion, the empirical studies reviewed did not always address the impact sociocultural influences may have on interviewees' accounts of features of compassion. Empathy, for example, is a concept widely used in UK policy and promoted in healthcare training. The dominance of empathy in UK nurses' descriptions of compassion may be rooted in participants' cultural background and experiences (Papadopoulos *et al.*, 2016b). As Brown et al. (2014) highlight, in their discourse analysis exploring the formulation and deployment of compassion in mental health settings, interviews inevitably reflect the professional socialisation and identity of participants.

Review of the empirical literature also highlights that the researcher's agenda and methodology influences findings. As qualitative research involves the co-construction of knowledge (Finlay, 2002), this is to be expected. However, in the research reviewed, the impact of underlying assumptions was not always clearly articulated. The purpose of Kneafsey et al's (2016) research, for example, was to develop formalised measures for recruiting nursing students through exploration of the values and attitudes necessary for compassion. The study's purpose suggests that an *a priori* assumption exists about the desirability of nurses possessing compassion before they enter training. As a result, the findings reflect the idea that compassion is innate. Similarly, in other studies, published interview questions assume compassion is positive or that it comprises certain features. For example, in Babaei et al's (2016) research, interview questions specifically asked about whether nurses empathise with patients, assuming empathy as a positive and necessary component of compassion.

There is also evidence that method selection influences the construction of compassion. Kneafsey et al. (2016) conclude from interviews that feelings are crucial to compassionate action. Similarly, Sinclair et al (2016a) report that the virtuous characteristics of the healthcare professional facilitate compassion. In both examples, features internal to the healthcare professional, whether a state or a trait, result in compassion. Participants refer to interactional practices but as a means to explicate internal processes. In comparison, Way and Tracy (2012) conclude from research involving participant observation and interviews that interaction is central to compassion. Research that utilises interview data, to explore participants understanding of compassion, is more likely to focus on thoughts and feelings. In contrast, ethnographic approaches involving participant observation are more likely to highlight and attempt to explicate compassionate practices.

Existing empirical research exploring conceptualisations of compassion, including the enactment of compassion, predominantly utilise interview data (see Table 2.2). There are however, a number of issues with using interview data to explicate how certain communication practices elicit or convey compassion. Firstly, given the prominence of compassion in policy documents (see section

2.4.2), healthcare professionals know what they are 'supposed' to do and there is a danger that interviews reflect this knowledge rather than actual practice. Secondly, interview data reports on what people say they do, and does not provide evidence regarding what people actually do (Potter and Weatherall, 1987; Benson and Hughes, 1983). Touch, for example, is regularly described as an element of compassionate interaction (Figure 2.2). However, Routasalo's (1999) literature review on touch concludes that expressive touch appears to be limited in nurse-patient interaction. Finally, as already alluded to, many of the compassionate communication practices described by interview participants are non-specific and ambiguous. In Tierney et al's (2016) study, exploring healthcare professionals' understanding of how compassion is delivered, "small acts of kindness" (p.7) are regarded as a driver of professional compassion. There is however, no expansion regarding what 'small acts' means. Studies that do provide examples of 'small acts' also provide different examples. These examples can vary from fixing pillows (Smith-MacDonald *et al.*, 2019), to having a chat (Straughair and Machin, 2021), to going and purchasing a patient's favourite soap (Durkin, Gurbutt and Carson, 2019; Smith-MacDonald *et al.*, 2019). While these examples suggest the descriptor 'small acts' is used to represent the characteristics of the healthcare professional, 'small acts' does not appear to be a universal specific action. Instead, 'small acts' appear to vary depending on the context in which the interaction occurs, including the patient's wants, needs and desires. Hence, whether the offer of a wheelchair is received as compassionate will depend on not only the context and how the wheelchair is offered but on the meaning the patient attaches to being offered a wheelchair. While one patient may regard the action as compassionate, another may interpret it as demeaning.

There is also evidence in the literature that some micro-level communication practices involved in compassion may not be consciously identified by participants in an interaction and therefore, cannot be expressed within interview data. Studies exploring compassion refer to nurses responding intuitively (van der Cingel, 2011, Way and Tracy, 2012) and patients recognising compassion intuitively, as the quotes below from Sinclair et al. (2016a) illustrate:

"I would have to say I know it intuitively. You feel it coming off them." (p.196)

"You could feel she was being just by their body language, the way they're talking to you, when they come in you can just tell by the feeling you get off them, their reactions" (p.196)

These quotes suggest that when participants talk about recognising compassion intuitively, they are suggesting that the expression and recognition of compassion may actually be embedded in interactional practices. One way to attempt to make these intuitive practices explicit is to measure them.

2.6.7 Scales measuring compassion

Within the literature search, a number of studies were identified which had either developed or used scales to measure compassion in healthcare settings. These include self-report measures in which healthcare professionals measure their own perceived compassion (Lee and Seomun, 2016b; Pommier, Neff and Tóth-Király, 2020; Tehranineshat *et al.*, 2021). Application of these self-report measures include correlating healthcare professional's compassion with both employment-related outcomes such as burnout and intention to quit (Park and Ahn, 2015), and patient-oriented measures such as missed nursing care (Kim and Lee, 2020) and medical errors (Sabanciogullari, Yilmaz and Karabey, 2021). Secondly, there are patient-report measures in which the patient assesses an individual or group of healthcare professionals' compassion (Burnell and Agan, 2013; Lown, Muncer and Chadwick, 2015; Lown *et al.*, 2017; Sinclair *et al.*, 2021). Finally, studies use observational scales to directly observe compassion during care-giving episodes (Alexander *et al.*, 2014; Denner *et al.*, 2019; Waisel *et al.*, 2020). Measures of compassion provide a different form of evidence regarding how compassion is conceptualised in healthcare. In this section, I will briefly discuss some of these conceptualisations focusing on patient-report measures of compassion. I will then discuss some of the limitations of using measures to assess if and how compassion occurs within interaction. Firstly, however, I will briefly discuss observational measures of compassion.

Observational scales, which directly measure compassion in healthcare settings, are arguably measuring the enactment of compassion within its interactional context. The researchers are directly observing interaction. While the literature search identified a study measuring doctors' compassionate responses to patients' emotional distress during palliative care decision-making consultations

(Alexander *et al.*, 2014), no details are given regarding how compassion was measured. Not only does this lack of clarity regarding the observational scale hinder reproducibility, it also means there is uncertainty regarding the construct measured and the conceptualisation of compassion. In other research, compassion is measured using observational scales developed to measure other constructs. Waisel et al (2020) use an empathy scale to measure compassion during simulated informed consent encounters. In another study, Denner et al (2019) report using an adapted version of the Person, Interactions and Environment (PIE) observational tool to measure compassion on hospital wards. The measure does include interactional features: for example, observing a patient laughing and smiling is an indicator of a positively enriching encounter, while observing a staff member engaging in little or no conversation with a patient is an indicator of a neutral interaction. The PIE observational tool was however, developed to describe person-centred care experiences in patients living with dementia (Royal College of Psychiatrists, 2011). Research using observational measures developed to measure other constructs potentially therefore equate compassion with the original construct. Rather than being conceptualised as a separate concept, in the examples given, compassion becomes synonymous with empathy or with person-centred care.

The same problem is true of some patient-rating scales measuring compassion. In order to measure the compassion of healthcare professionals on inpatient wards, for example, Kret (2011) uses a ten-point scale that asks patients to measure whether their healthcare professional is warm-cold, pleasant-unpleasant, compassionate-distant, sensitive-insensitive and caring-uncaring. There is however, no discussion in Kret's (2011) paper, or the paper in which the scale is originally used (see Fogarty et al, 1999), about why or whether these specific characteristics measure compassion. For other patient-rating measures of compassion, published research does report on the validity of the measures and make claims that the measure relates to the construct compassion (Burnell and Agan, 2013; Lown, Muncer and Chadwick, 2015; Sinclair *et al.*, 2021). There are however, variations in the components they include in the measurement of compassion. Some of these variations are seen in the comparison of the components of the Schwartz Center Compassionate Care Scale (Lown, Muncer and Chadwick, 2015; Lown *et al.*, 2017) and the Sinclair Compassion Questionnaire (Sinclair *et al.*, 2021) shown in table 2.4.

Table 2.4 Components of Schwartz Center Compassionate Care Scale and Sinclair Compassion Questionnaire

Components of Schwartz Center Compassionate Care Scale	Components of Sinclair Compassion Questionnaire
-Express sensitivity, caring and compassion for your situation? -Strive to understand your emotional needs? -Consider the effect of your illness on you, your family, and the people most important to you? -Listen attentively to you? -Convey information to you in a way that was understandable? -Gain your trust? -Always involve you in decisions about your treatment? -Comfortably discuss sensitive, emotional or psychological issues? -Treat you as a person not just a disease? -Show respect for you, your family and those important to you? -Communicate test results in a timely and sensitive manner? -Spend enough time with you?	-Feeling cared for -Genuine concern -Communicated sensitive -Attentive -Provided comfort -Very supportive -Provided care -Spoke with kindness -Saw as person -Behaved in caring way -Really understood needs -Good relationship -See my perspective -Warm presence -Sincere

Some of the differences in the components of the Schwartz Center Compassionate Care Scale (Lown, Muncer and Chadwick, 2015; Lown *et al.*, 2017) and the Sinclair Compassion Questionnaire (Sinclair *et al.*, 2021), shown in Table 2.4, relate to the underlying assumptions regarding compassion that inform the measures. Sinclair et al (2021) define compassion as:

"A virtuous response that seeks to address the suffering and needs of a person through relational understanding and action." (p.1)

The components of the Sinclair Compassion Questionnaire reflect the belief that the virtuous characteristics of the healthcare professional are the foundation of compassion. The patient assesses the care episode based on whether they

perceived that the healthcare professional exhibited behaviours such as being sincere, behaving in a caring way and showing genuine concern. In comparison the Schwartz Center Scale (Lown, Muncer and Chadwick, 2015) defines compassion as:

"Recognition, understanding, emotional resonance and empathic concern for another's concerns, distress, pain or suffering, coupled with their acknowledgement, motivation and relational action to ameliorate these conditions." (p.1005)

Lown et al's (2015) definition of compassion is therefore not about the characteristics of the healthcare professional. Instead, compassion stems from affective and cognitive processes including recognition, understanding, feeling and motivation. As a result, the components of the Schwartz Center Compassionate Care Scale focus on attempting to establish whether the patient felt understood and the quality of care delivered.

While there are potential differences in how compassion is conceptualised that feed through into the components of the Schwartz Center Compassionate Care Scale and the Sinclair Compassion Questionnaire, the scales do possess similarities. In both measurement scales, components such as 'listening attentively' or 'warm presence' are directly attributed to the characteristics of the healthcare professional. Listening is seen as directly corresponding to attentiveness in the healthcare professional. Actions such as listening and 'communicating test results' become proxy measures for the characteristics and/or affective and cognitive processes of the healthcare professional. As Baumeister et al (2007) argue in relation to the use of behaviour measures in social psychology, behaviour measures can show what people think and feel; they cannot however, show what actually happens. Instead, components of patient-rating scales measure patient's perceptions about what occurred during a consultation, and attribute these findings to the characteristics or cognitive processes of the healthcare professional. Take the example of 'communicating test results in a timely and sensitive manner'. Responses do not clarify if and how the test results were delivered. In each scale, therefore, the patient's perceptions are claimed to accurately represent the characteristics or affective and cognitive processes of the healthcare professional.

There are also wider issues with measures of compassion, which apply to patient-reported, healthcare professional-reported and observational scales that measure compassion in healthcare settings. In addition to concerns about the reliability and validity of some of these measures in previous reviews (see Papadopoulos and Ali, 2016; Strauss et al, 2016[6]), there are issues with assuming such scales measure the enactment of compassion within its interactional context. All apply *a priori* definitions of compassion to its measurement. These external indicators of compassion assume that compassion occurs in the same way in all contexts, and that participants measure compassion in the same way. Responses to items such as 'spend(ing) enough time with you' or 'provid(ing) comfort' will depend on respondents understanding about what these features mean. Patients will vary in beliefs about how much time is enough time, and this will also vary according to the context. For a patient who is experiencing loneliness, perceptions about how much time is enough, may be higher than for the critically ill patient who has strong family support. The same issues are also evident in observational measures of compassion. In the PIE observational checklist, for example, a staff member displaying a caring attitude, while assisting with feeding or mobilising, is an indicator of an enriching encounter (Denner *et al.*, 2019). Observers may attribute different meanings to these encounters, though assessing inter-rater reliability can overcome this (Burns and Grove, 2005). However, differences may still exist between the meaning an observer attaches to an action, and the meaning the patient and/or healthcare professional attach to the event. In relation to the offer of a wheelchair, an observer may rate the offer as an enriching encounter. However, a patient may find the offer of a wheelchair demeaning or humiliating. Measures therefore decontextualize behaviours and assume that they can be independently judged as positive or negative. Additionally, if compassion is relational (Lown, Muncer and Chadwick, 2015; Sinclair *et al.*, 2021), involving interaction between the nurse and patient, scales cannot show how such interaction occurs (Dewar, Pullin and Tocheris, 2011; Dewar and Nolan, 2013). Scales do not acknowledge the patient's role in the display of suffering, or patient responses that indicate certain actions are, or are not, received as compassionate.

[6] Both these reviews include the patient self-report measures by Burnell and Agan (2016), Kret (2011) and Lown, Muncer and Chadwick (2015).

2.7 Defining compassion

The literature review so far has shown that although compassion is widely researched, it is often conceptualised as either an innate characteristic of the healthcare professional or an affective and/or cognitive process that motivates the healthcare professional to alleviate suffering. This is despite the fact that research shows that interaction is an important component of compassion, and different features of interaction have been linked to compassionate care (Figure 2.2). However, these interactional components are regarded as directly corresponding to the compassionate characteristics or cognitive and affective processes of the healthcare professional. While ethnographic research has explored compassion within its macro-institutional context (Way and Tracy, 2012), there is still a lack of evidence regarding how compassion is enacted within its local interactional context. There is therefore a need to consider how compassion is enacted within its interactional context. However, in order to do this, it is necessary to have a definition of compassion, which neither makes *a priori* assumptions about the interactional practices that comprise compassion, nor makes a simplistic attribution of interactional practices to the characteristics of the healthcare professional. Such a definition also needs to recognise that compassion is a dynamic construction, occurring within the context of interaction between the healthcare professional and patient.

Table 2.5 presents a selection of definitions of compassion, which have been regularly adopted in empirical research. Other researchers reviewing definitions of compassion have identified a lack of consensus regarding definitions of compassion (Burnell and Agan, 2013; Papadopoulos and Ali, 2016; Strauss *et al.*, 2016). As the definitions in Table 2.5 show, there are subtle variations in how compassion is defined. As already reviewed some definitions suggest compassion is about an awareness of suffering and attempts to alleviate suffering (Gilbert, 2010; Sinclair *et al.*, 2016a), while other definitions suggest this response to suffering involves an emotional reaction or feeling (Dewar, Pullin and Tocheris, 2011; Kanov *et al.*, 2004). Similarly, some definitions suggest that compassion involves the wish to relieve suffering (Chochinov, 2007), while other definitions suggest compassion involves actions to address another person's suffering (Durkin, Jackson and Usher, 2020; Sinclair *et al.*, 2016a).

Table 2.5 Examples of definitions of compassion either developed following research or widely adopted in research

Chochinov (2007) (p.186)	"Compassion refers to a deep awareness of the suffering of another coupled with the wish to relieve it."
Dewar et al (2011) (p.32)	"the way in which we relate to other human beings. It can be nurtured and supported. It involves noticing another person's vulnerability, experiencing an emotional reaction to this and acting in some way with them, in a way that is meaningful for people."
Durkin, Jackson and Usher (2020) (p.146)	"a virtuous response involving awareness of and participation in the suffering of another conveyed through action intended to reduce the suffering observed."
Gilbert (2010) (p.xiii)	"basic kindness, with a deep awareness of the suffering of oneself and of other living things, coupled with the wish and effort to relieve it."
Kanov et al (2004)	"Noticing another's suffering, feeling the other's pain and responding to that person's suffering."
Sinclair et al (2016a) (p.193)	"A virtuous response that seeks to address the suffering and needs of a person through relational understanding and action."

In addition to the differences between the definitions of compassion in Table 2.5, there are also similarities. Firstly, all the definitions contain references to either the affective or cognitive processes that the healthcare professional engages in - 'awareness', 'wish(ing)', 'emotional reactions', 'feeling' and 'understanding'. Secondly, perhaps with the exception of Chochinov (2007), all the definitions of compassion in Table 2.5 suggest that compassion involves action to alleviate suffering. However, again, there are subtle differences in the presentation of action in relation to other components of compassion within the different definitions. In some definitions, actions to reduce suffering convey the healthcare practitioner's awareness and participation in suffering, which comprise compassion (Durkin, Jackson and Usher, 2020). As already discussed, in relation to scales measuring compassion, assuming that we can infer through interaction what other people are thinking or feeling is problematic. These inferences also ignore both the context in which the encounter occurs, and whether the recipient regards the action as compassionate. However, in Kanov et al's (2004) definition of compassion, action is seen as an independent component. That is, the compassionate action is not assumed to represent the thoughts and feelings of the person displaying compassion. The focus on action within Kanov et al's (2004) definition would allow the exploration of the enactment of compassion within its interactional context. However, their definition still includes noticing and feeling, which would require a focus on beliefs and understanding.

As the present research is interested in how compassion is enacted within its interactional context, rather than what a nurse thinks, feels or believes, for the purposes of this research compassion is defined as:

"A nurse's explicit or implicit acknowledgement of the patient's suffering and/or the observable actions that the nurse undertakes (in an attempt) to reduce or alleviate suffering."

In addition to this definition's explicit focus on interaction, it also avoids assumptions about the specific communication practices involved in compassion, recognising that these will vary by context. The definition developed would therefore allow the exploration of interactional practices which exhibit compassion within the context of nurse-patient interaction.

2.8 Conclusion

In this chapter, I have outlined current conceptualisations of compassion in theory, policy and empirical research. This review suggests that there are ongoing debates regarding compassion in healthcare, and in wider society. These include the values comprising compassion, the importance of different psychological processes in producing compassion, the role of patient suffering or need, and the interactional practices which comprise compassion. There are however, common themes emerging within the literature that conceptualises compassion in healthcare. Many of these themes locate compassion within the healthcare professional. Compassion is conceptualised as a characteristic of the healthcare professional, a value the healthcare professional possesses, and an affective and/or cognitive process the healthcare professional engages in. The literature review shows that interaction is also an important feature of compassion, and different interactional features have been conceptualised as displaying compassion (see Figure 2.2). Many of the interactional features identified are however, used to describe the characteristics or psychological processes of the healthcare professional. The research reviewed predominantly uses interviews to explore compassion. Research using interviews is based on accounts of what occurred within interaction, rather than what actually occurred within the interactional context. A gap in knowledge therefore remains regarding how compassion is actually enacted within its interactional context. In the next chapter, I will outline the methodological basis of conversation analysis, the approach which I will use to investigate the enactment of compassion within the context of nurse-patient interaction.

Chapter 3 Methodology

3.1 Introduction

Scoping the literature on compassion in nurse-patient interaction shows that both patients and professionals describe compassion as an important component of nursing care. Yet, there is a lack of clarity regarding how compassion is enacted within the context of nurse-patient interaction. While quantitative observation and self-report measures have been used to measure compassion, they apply external criteria to the measurement of compassion. Responses to self-report measures vary according to the respondent's understanding and the context. As a result there is a lack of clarity regarding what exactly they are measuring. In comparison findings from interviews have described patients' and/or healthcare professionals' experiences and perceptions of compassion, but they cannot show how nurse and patient actually enact compassion during nurse-patient interaction. In order to address this gap in knowledge, I will use conversation analysis (CA) to explore the enactment of compassion in nurse-patient interaction. Here I begin by discussing the methodological basis of conversation analysis, focusing in particular on Goffman's (1983) notion of the interactional order, and Garfinkel's (1984) ethnomethodology – a term for the study of the methods people use to produce the social world and their understanding of it. Next, I outline the foundations of conversation analysis as applied to everyday talk, prior to discussing both how conversation analysis has been used to provide insights into emotions and other seemingly intangible entities, and how it has developed as a means for exploring interaction in institutional settings.

3.1.1 The Interaction Order

In a special issue of the journal American Anthropologist devoted to the ethnography of communication, Goffman (1964) proposes that face-to-face interaction should be examined in its own right, as opposed to external structures and pre-defined categories, such as role or class being seen to determine speech. Throughout subsequent works, using both formal ethnographic observations and informal or passing observations, Goffman outlines how the organisation of action, perception and experience are maintained within face-to-face encounters (Goffman, 1983). The culmination of

Goffman's work is perhaps best seen in his address to the American Sociological Association (1983) where he outlines the interaction order, claiming that it should be recognised as a "substantive domain in its own right" (p.2). That is, how people participate with others in their co-presence has its own internal structure or order. As Rawls (1987) summarises, Goffman does not begin with social structures and individual agents who must either conform to or resist some expected behaviour. He argues that the interactional order functions independently of wider social structures and pre-defined categories such as 'nurse' or 'compassion'. However, as discussed in the literature review, policy outlines pre-defined universal compassionate values or behaviours and expects healthcare professionals to conform (Department of Health, 2008; Department of Health, 2015). Similarly, subsequent research using observational checklists or self-report measures make *a priori* claims about the characteristics or behaviours, which represent compassion, to ascertain if nurses are compassionate. While similar scales have been used to measure behaviour change following interventions to improve compassionate nursing care, findings have shown mixed results (Blomberg *et al.*, 2016). One factor which may contribute to the mixed results is that, as Goffman (1983) identifies, measures do not attempt to examine interaction as a self-functioning, independent system, but as representative of a pre-defined category e.g. compassion, which is external to the interaction.

One of the key features of 'social orders' is that they are self-sustaining, independent structures, which are maintained through their own internal obligations and constraints. The commitments and obligations, which maintain and sustain the interaction order are embedded in 'face' considerations (Goffman, 1955). The term 'face' describes the positive social value that participants give and receive during social interaction. 'Face' is not however, an internal trait or characteristic, but a feature of interaction - something:

"diffusely located in the flow of events in the encounter" (Goffman, 1955, p.214).

An individual's 'face' is determined by the stance others assume the individual has taken during an encounter. Interaction is therefore inherently 'risky' - there is always a risk that a 'face-threat' will occur and the individual will lose 'face'. If, as Goffman (1983) suggests, 'face' is central to an individual's identity and wellbeing, participants are invested in complying with the norms and rituals of

interaction, in order to protect their 'face'. This proposal that interaction is maintained through 'face' obligations and constraints has two potential implications for the study of compassion in nurse-patient interaction. Firstly, there is a potentially close relationship between 'face' and compassion. If 'face-threats' negatively impact an individual's identity and wellbeing, they could be a cause of suffering. Not maintaining 'face' during interaction could therefore potentially be seen as an uncompassionate act towards a patient. Secondly, the potential that 'face' obligations and constraints may work independently to the acknowledgement and alleviation of suffering also requires consideration.

3.1.2 Ethnomethodology

Harold Garfinkel, a sociological contemporary of Erving Goffman, was also interested in the production of everyday, mundane interaction. While Goffman's (1964; 1983) work focuses on describing a distinct, self-sustaining interaction order, Garfinkel's (1984) work provides an explanation of how people in everyday settings achieve mutual understanding. Garfinkel (1984) terms this study of the methods people use to produce the social world and display their understanding of it, ethnomethodology. As will now be discussed, Garfinkel was influenced by, but diverged from the thinking of both Parsons (1937) and Schutz (1962).

Both Parsons and Garfinkel were interested in human action and order in society; however, their perspectives differed (Heritage, 1984b). Garfinkel's (1984) focus was on how individuals achieve and sustain social order within interaction, and he questioned theories such as structural functionalism. Parsons (1937) had proposed structural functionalism as a method for explaining how social order is possible. Structural functionalism proposes that external rules, which are internalised through socialisation, govern an individual's actions. These rules are seen as specifying how people should behave in order to sustain order in society (Murphy *et al.*, 1998). Garfinkel (1984) argues that theory premised on the notion that people follow internalised, institutionalised rules turns the individual into "a judgemental dope" (p.68). That is, structural functionalism ignores the individual's agency and ability to interpret and adapt to what is happening within a specific context (Heritage, 1984b). Within the literature review, I referenced observational studies, which use predefined checklists of compassionate behaviours to

determine whether certain types of nurse and/or healthcare professional display compassionate behaviours (see Alexander et al, 2014; Denner et al, 2019, for examples). Such studies regard the behaviours as universal and, as such, ignore both the nurse and patient's agency and ability to interpret and adapt to what is happening within a specific context.

Garfinkel not only raises questions about the role of the individual in structural functionalism, he also expresses concerns about the findings that result from science based on structural functionalism. As scales measuring a nurse's compassion or a patient's experience of compassionate care exemplify, findings are a product of the researcher's perspective (vom Lehn, 2019). Nurses who do not comply with certain behaviours on attitude or behaviour scales are labelled as not compassionate or not having internalised the correct norms. Garfinkel argues that such approaches ignore the involvement of participant's common-sense understanding in maintaining social order. Instead, researchers need to ask:

"how do social actors come to know, and know in common, what they are doing and the circumstances in which they are doing it?" (Heritage, 1984b, p.76)

In relation to nursing and compassion, for example, this question can be thought of in terms of how nurses determine within each interactional context when it is appropriate to offer a wheelchair or touch a patient, and when and how do patients show that these actions have been received as compassionate?

A second influence on Garfinkel and ethnomethodology were Schutz's (1954) claims that the world is made meaningful through an individual's experience and interpretations of that world. Rather than external structures organising individual action and society, individual agents are integral to the construction of a meaningful world. Entities such as 'compassion' and 'nursing', and identities such as 'nurse', are constructed through an individual's experiences and interpretations of those experiences. As Schutz (1954) acknowledges, the exact meaning individuals attach to concepts and events such as compassion are inaccessible; however, individuals use common-sense knowledge to understand others and everyday social reality. Achieving this mutual understanding or intersubjectivity occurs through *verstehen*. That is, the interpretive understanding of the subjective motivations individuals attach to actions.

Schutz (1953) argues that social scientists can use *verstehen* to reveal people's understanding of social life. The purpose of social science is therefore for the social scientist to attempt to understand the meaning of an action from the perspective of an actor, and to investigate and report on people's common-sense understanding.

While Schutz's largely philosophical writings do not describe how interpretivism[7] should be practically applied to scientific inquiry (Heritage, 1984b), his work has been influential in the development of a number of different methodologies. Interpretivism has allowed social scientists to explore new areas, and methodologies including phenomenology have developed which attempt to describe individual's perceptions and understanding of experiences (Heritage, 1984b). There are, however, challenges in the empirical application of Schutz's philosophical writings. Firstly, by rationalising the individual's innumerable and revisable meanings the researcher risks violating the individual's point of view (Heritage, 1984b). Secondly, while researchers applying Schutz's proposal (that meaning is generated through understanding the individual's experiences and interpretations) will generate an image of the individual's meaning of some action or concept, the image is static (Heritage, 1984b). An interview about compassion, for example, will create an image of what compassion is in that moment; however, that will not necessarily be applicable to all moments for that person, or for other people. Thirdly, Schutz's claim that the intersubjective world is based on co-operation between individuals has been challenged for not clarifying how this co-operation is achieved (Heritage, 1984b). Garfinkel's work attempts to address some of these issues arising from Schutz's work. Rather than engaging in research that uses *verstehen* to uncover the shared meanings people attach to objects and events, Garfinkel claimed that enquiry should develop from questioning how order is achieved through intersubjectivity:

"how men, isolated yet simultaneously in an odd communion, go about the business of constructing, testing, maintaining, altering, validating, questioning, defining an order together." (Garfinkel, 1952 cited by Heritage, 1984b, p.71).

[7] Approaches in the social sciences, whose foundations are in understanding or interpreting human actions and meanings (Benton & Craib, 2011).

Hence, in order to understand how an action is constructed (or not) through interaction as a compassionate action, investigation would focus on how nurses attempt to convey compassion and how their attempts are received (responded to, appreciated – or not) by the patient. Rather than focusing on obtaining people's understanding of compassion through *verstehen*, investigation focuses on how people (in this case, nurse and patient) achieve mutual understanding about what is occurring in an interaction.

Through his work Garfinkel (1984) shows how intersubjectivity is achieved and maintained within interaction. These demonstrations included showing how the documentary method of interpretation worked in action, the indexical nature of language, and how accountability within interaction sustains order or co-operation within interaction. With regard to the latter, Garfinkel's breaching demonstrations, in which participants were deliberately exposed to situations where the normal expectations of interaction were disrupted, show how co-operation is maintained within interaction. Within these demonstrations, which include participants not following the rules of a game or a participant treating the meaning of another's common-sense talk as not self-evident, Garfinkel shows that participants are held accountable for not following the 'reciprocity of perspectives'. When, for example, a participant asked for clarification regarding what 'tired' or a 'flat tyre' meant, interactional breakdown occurred and the participant exhibiting a lack of understanding was held accountable for breaching expectations regarding the maintenance of common-sense understanding and halting progression of the interaction.

As with Goffman's interaction order, Garfinkel's demonstrations of the accountability embedded within interaction reinforces that interaction has its own internal rules or order. The idea that maintaining intersubjectivity is an accountable action, which can be observed during interaction, also has implications for studying compassion in nurse-patient interaction. In studies exploring patients' and healthcare professionals' experiences and perceptions of compassion touch is often described as a compassionate act (Bramley and Matiti, 2014; Durkin, Jackson and Usher, 2021b; Smith-MacDonald *et al.*, 2019; Way and Tracy, 2012), and could be included as a compassionate act on an observational scale. While a patient may display that a touch is compassionate by, for example, leaning in, a patient could pull away from a touch

demonstrating that they don't experience it as compassionate. Secondly, if participants are held accountable for maintaining mutual understanding and interactional order, these activities may take priority over external recommendations regarding how compassionate interaction should be delivered.

In addition to showing how participants maintain co-operation within interaction, Garfinkel also provides evidence for the documentary method of interpretation[8], and shows how the method occurs within interaction. The documentary method refers to the notion that individuals will treat the presentation of an object, whether this be a physical object or an utterance, as evidence of an underlying pattern i.e. that a nurse is being compassionate (or not). Garfinkel exemplifies the documentary method within student counselling demonstrations. Student participants were led to believe that they were enrolling in a new type of counselling. Researchers, in another room, gave randomly generated yes/no answers to questions students posed about an issue that they discussed in the demonstration. Following each answer by the researcher, students recorded their reflections. Students' reflections showed how they were able to take the researcher's random responses as making sense. Through the student's sense-making, the event came retrospectively to be interpreted as a counselling advice session. Garfinkel argued that these demonstrations showed that rather than talk (such as yes/no answers in the counselling demonstration) being interpreted literally, participants applied underlying common-sense understanding about what was being done and the context to sustain a particular version of events i.e. that a counsellor was offering advice. Hence, during interaction, participants engage in 'seen but unnoticed' interpretive work to maintain their understanding of events/proceedings. While previous research using interviews may show that participants retrospectively define a practice, such as listening or a touch, as compassionate, they cannot show how participants came to interpret them as a compassionate/uncompassionate act, within the interactional context.

[8] The documentary method of interpretation is hereafter referred to as 'documentary method'.

Garfinkel's work into the documentary method also shows that language is indexical. That is, the meaning of a word e.g. 'yes' or 'no' depends on the context in which it is used. A listener will 'fill in' the meaning of an utterance with information about who the speaker is, their status, preceding talk and what is likely to happen next (Potter and Weatherall, 1987). As discussed earlier, research using surveys or observational checklists to assess a nurse's compassion assumes *a priori* that the criteria correspond with compassion. Garfinkel shows how words are indexical, with intersubjectivity emerging over the course of an interaction. The interpretive work participants do over the course of an interaction has both retrospective and prospective significance for the sequence of an interaction. That is, the meaning of a prior utterance is only established by a recipient's response within that context, and a recipient's response is constructed based on the prior utterance i.e. interaction is both context shaping and context renewing. Hence, participants within an interactional context construct social reality. Participants:

"find that their actions reflexively contribute to the sense of the scene, which is undergoing development as a temporal sequence of action." (Heritage, 1984b, p.104)

While policy, training and leaders may suggest, for example, that listening or touching a patient corresponds with compassionate action, Garfinkel's approach would suggest that compassionate actions cannot be established *a priori*. Instead, the responses of both the nurse and patient, made reflexively during the course of interaction, will determine compassionate action in that specific context. That is because with every action/utterance, the recipient has a myriad of options, which were not previously available. A nurse observes a patient struggling to walk, or a patient reports they are struggling to walk. Through this observation or report, options become available to the nurse: offering a wheelchair, giving a wheelchair or encouraging the patient to continue walking, among others. If, for example, the nurse offers a wheelchair, not only does the patient have options regarding whether they accept the wheelchair, they also have options regarding whether the action is actually regarded as an offer. With each utterance, the next set of options become visible. Regardless of what each person does at each stage, even doing nothing (e.g. leaving a patient who is finding it difficult to walk to continue walking) the normative accountability (or not) of each participant's turn is also visible, for example, outrage at being offered a wheelchair.

Garfinkel argued that norms are doubly constitutive within interaction. Norms provide the understanding and accountability to allow an interaction to progress 'as normal', and the recognition that an action has departed from the norm/expected common-sense understanding (Heritage, 1984b). Although Garfinkel claims that the need for people to show that they understand one another means that reflexively people choose to follow interactional norms, this does not mean that those norms are deterministic of conduct. That is because the context is always different, therefore the rules will always be applied as if for the first time. Returning to the example of offering a wheelchair, for one patient this may be the compassionate option, which reduces pain and suffering, but another may receive the offer as demeaning and increasing dependency. In the latter case, offering a wheelchair could be perceived and received as uncompassionate. Hence, getting at how compassionate actions are enacted/constructed in nurse-patient interaction needs to recognise that concepts such as compassion are not proscriptive and deterministic but occur within a context in which nurse and patient:

"concertedly recognise and act upon – and in concertedly recognising and acting, create and recreate, maintain, restore or alter – the phenomena (of social organisation). (Heritage, 1984b, p.123)

As a result, research needs to entail describing and understanding the social world by examining "the methods, procedures, practices etc. that members use in constructing and making sense of this world." (Benson & Hughes, 1983, p.30). One approach to examining these methods, procedures and practices, which will be discussed in the next section, is conversation analysis.

3.2 Conversation Analysis

Sacks' Lectures (1995) and seminal work (Schegloff and Sacks, 1973; Sacks, Schegloff and Jefferson, 1974) outline conversation analysis as an approach for investigating and describing the methods people use to achieve social actions. The foundations of the conversation analytic approach to investigation derive from both Goffman and Garfinkel's work. Conversation analysis recognises the interaction order as a distinct and legitimate site for study, and early conversation analysts took on Goffman's (1983) call for interaction to be studied as an entity in its own right (Heritage, 2001; Heritage, 2009). In addition,

Garfinkel's proposals about how participants achieve and maintain mutual understanding during interaction, provide the basis for conversation analysis' focus on the practices participants use to facilitate intelligibility, and construct actions within the context of turn-by-turn interaction (Heritage, 2001; Heritage, 2009). The resulting conversation analytic approach to the study of interaction provides a method for studying talk in its own right, rather than focusing on what the content of talk tells us about a concept or experience. Sacks (1984) claims that social science which relies on theory or hypothesis about the world obscures the features of the event under investigation. As already discussed hypothesising that touch or the offer of a wheelchair is a compassionate action, potentially obscures other features of the offer of a wheelchair within its specific interactional context. Instead of relying on theory or hypothesis, as the quote below shows, Sacks (1984) claims that to be an actual science, social scientific research needs to use detailed observation to theorise.:

"It is possible that detailed study of small phenomena may give an enormous understanding of the way humans do things and the kind of objects they use to construct and order their affairs." (Sacks, 1984, p.24)

In the present research, investigating nurse-patient interaction in detail may therefore provide valuable information about how compassion is achieved within context.

While conversation analysis rejects *a priori* theorising about what is occurring during an interaction, as an approach it has a number of underlying principles. Firstly, these principles include that social action and interaction are structurally organised (Heritage, 1984b; Heritage, 2009). That is, the practices participants use to perform actions are orderly and normatively oriented to. There are for example, a variety of practices a participant may use to make the action of offering, and accepting or declining recognisable to others. If the practices interactants use to perform actions are orderly, investigating this order within situ becomes possible. The second principle is, that participants' talk and embodied actions are embedded within the context (Heritage, 1984b). As discussed above the actions performed by a participant's talk both shapes the context and renews the context. By researching compassion within the context of nurse-patient interaction, both the role of the nurse and patient in the construction of actions therefore becomes possible. The final underlying principle of conversation analysis is that no detail of interaction can be dismissed

a priori (Heritage, 1984b). Conversation analysis is an inductive method, which uses detailed observation to describe the practices people use to make themselves understood (Clayman and Gill, 2004). Describing how these practices occur is part of understanding how participants construct actions such as an offer, or compassion, within the interactional context. Dismissing practices *a priori* could result in what Heritage (1984b) describes as "premature theory construction" (p242). As will now be discussed, the need to ensure empirical analysis is based in the specific details of the research materials, and avoids premature theorising, results in a number of recommendations regarding how conversation analysis should be undertaken.

Foundational work in conversation analysis not only outlines the underlying principles, it also outlines the practices the researcher should adopt, if they are to undertake naturalistic observational social science. Early conversation analysts used audio-recordings of naturally occurring conversations. Sacks (1984) claims that audio-recordings provide a "good enough" record of what happened (p.26). Being able to listen to the participants' talk repeatedly, allows exploration of the temporal aspects of the interaction i.e. who spoke when. The micro-analysis of who spoke when and how a turn is constructed cannot be obtained from observation alone. Recordings also overcome problems with the possible gap between what people say they do and what actually occurs (Drew and Heritage, 1992). While early conversation analysts collected audio-recordings of data, as video-recording has become more accessible, conversation analysts have increasingly used video recordings of participants' interaction. Video-recording captures embodied practices and therefore increases the participants' practices available for analysis (ten Have, 2007). In situations such as nurse-patient interaction, where people are engaged in face-to-face interaction, the collection of video-recordings allows access to the embodied practices people use to make themselves understood. The use of audio-visual recordings also allows the researcher to undertake the detailed transcription, required for conversation analysis. This detailed transcription, based on Jefferson's notation system (reproduced 2004, see Appendix 8) aims to capture both what was said and how it was said (ten Have, 2007). In conjunction with the recording, the transcript supports the analyst in identifying the practices participants use to build an action (Hepburn and Bolden, 2013).

In order to use naturalistic observation to generate knowledge about how people construct actions, early conversation analysts engaged in a process of 'unmotivated looking'. Sacks (1984) states that approaching data in an "unmotivated way" (p.27), without interest in a specific problem, means that solutions can be found to problems that had not even been identified. Other eminent conversation analysts have reiterated that analysis should begin without any "pre-specified analytic goals" (Schegloff, 1996, p.172). While unmotivated looking allows the grounding of analysis in the interaction, and reduces the risk of theorising prematurely about interactants' practices, there are a number of reasons why unmotivated looking may be impractical in some situations. Firstly, the need for a clearly formulated research question, in order to obtain funding and access, makes unmotivated looking an idealistic position for most researchers. Secondly, entirely unmotivated looking may not be possible due a researcher's theoretical background and experience (Clayman and Gill, 2004). In health services research utilising conversation analysis, there is usually an overarching aim to improve practice and patient care, which influences the focus of analysis. Finally, as will be discussed later, over the last fifty years a number of overarching interactional features e.g. the turn-taking system and sequence organisation, have been identified using conversation analysis. For contemporary conversation analysts, ignoring this existing knowledge is not possible (Clayman and Gill, 2004; ten Have, 2007).

The inability to apply 'unmotivated looking' may not however, prevent methodological rigour. Perhaps more important than 'unmotivated looking' is 'ethnomethodological indifference'. By ethnomethodological indifference I mean that the analyst avoids making assumptions about the adequacy or value of participant's practices (Heritage, 1984b). Observational checklists associate practices such as touch or eye contact with 'good' nursing practice. Similarly, policymakers and participants in interviews judge certain practices or behaviours as compassionate (or uncompassionate). As a nurse who has perhaps been conditioned into some of these assumptions about what 'good' or 'bad' compassionate practice entails, there will be a need to recognise where premature assumptions are being made about the actions that participants' practices are performing. Through reflexivity and an acknowledgement of any pre-conceived ideas about what constitutes an action, the researcher can move towards abandoning value judgements about participant's practices. While not 'unmotivated', the adoption of this ethnomethodological indifference allows the

researcher to maintain a focus on the participant's orientation, and avoid pre-emptive theorising.

As mentioned above, previous conversation analytic work has identified a number of overarching structures of interaction, which can be used to guide analysis. These include turn-taking, sequence organisation, turn-design and repair, which will now be discussed briefly in turn.

3.2.1 Turn-taking organisation

One of the earliest structures of interaction identified by conversation analysts was the organisation of turn-taking (Sacks, Schegloff and Jefferson, 1974). That is, the system which means one person usually speaks at a time and finely co-ordinated transitions occur without long periods of silence or overlapping talk. Sacks et al (1974) use data from everyday interaction to show how participants manage their talk one-person at a time, with minimal overlap, even though features such as the content, length etc. of a turn may vary. They present a system, which is context-free (applies to any context or time in interaction) but is context-sensitive (varies according to the interaction). Sacks et al (1974) provide evidence for two components, turn-construction and turn allocation, and a set of rules that show how the turn-taking system functions. The turn construction unit is the word, phrase, clause or sentence a speaker uses to construct their turn. Based on lexical choices, prosody, grammar and embodied resources a speaker projects what type of unit they are constructing, and when that turn construction unit is likely to be complete. Projection of completion of a turn is essential for smooth transition of speakership at transition-relevance places, which occur at the completion of a turn-construction unit. At transition relevance places, speakership may (or may not) change depending on the turn allocation component of the system. Turn allocation can occur either by the current speaker selecting the next speaker, or via self-selection. While naming the next speaker is one option, a current speaker has many options for the selecting the next speaker e.g. asking a question in a two-party interaction usually selects the other as next speaker. The rules which Sacks et al (1974) propose are that if the current speaker selects the next speaker, then they have the right and are obliged to take the next turn. If a next speaker is not selected, then another participant may select to speak. The current speaker may also continue, unless another self-selects. Participants'

normative orientation to these rules for successful turn-taking allow both intersubjectivity and progressivity. Without the turn-taking system, speakers would talk over each other, resulting in confusion and an inability to progress actions.

While claiming that the turn-taking system is context-free and can be applied to any interaction, Sacks et al (1974) also claim that turn-taking is context-sensitive. That is, the system can accommodate the different content, turn sizes, and orders of participation, which are required to achieve different actions. This context sensitivity is possible because the system is "locally managed, party-administered and interactionally managed" (p.696). By locally managed, Sacks et al (1974) mean that the system deals with one turn at a time. That is, the turn-taking system 'locally' manages one turn at a time, as they arise (i.e. each turn is new and done as if for the first time). As each turn construction unit is new and done for the first time, it is therefore managed by the participants in the interaction and can accommodate different actions. While Sacks et al (1974) outline turn-taking organisation, what exploring turn-taking allows the analyst to do is develop an account of what is going on for participants. This party administration means that the organisation of turns can be used by the analyst to identify the actions being performed and participants' orientations (ten Have, 2007).

3.2.2 Sequence organisation

Sequence organisation, or the organisation of courses of action through successive turns-at-talk (Schegloff, 2007), is a second fundamental structure of interaction. While sequence organisation depends on the co-ordination of turns-at-talk, sequence organisation also influences the turn-taking system. An action such as a question makes an answer relevant and in effect influences turn allocation and speakership. Sequence organisation's most basic feature is adjacency pairs (paired actions), which occur turn-by-turn (in adjacent turns) to form a sequence (e.g. question-answer, request–grant/reject, offer-

accept/decline and complaint – apologise/deny/excuse)[9]. Adjacency pairs are fundamental to intersubjectivity and progressivity (Heritage, 1984b). Through sequences of talk, participants show their understanding of one another and construct actions. Participants' understandings, and their building of actions, are available to the analyst, rather than the analyst making assumptions about the action being performed.

Just as the turn-taking system has a normative order, so sequence organisation has a normative order. The initiation of a first pair part makes the second pair part conditionally relevant. That is, there is an expectation that a second pair part should follow. Not responding with the relevant next is an accountable action, which participants orient to (Heritage, 1984b). A speaker, for example, may hold a recipient accountable for not answering, by repeating the question or requesting an answer. As participants orient to these breaches, they are also available to the analyst. Investigating sequence organisation therefore not only provides opportunities to identify what actions are commenced but also to investigate where an action may be withheld or stopped (Heritage, 2004). The investigation of sequence organisation can therefore reveal the consequences of various actions.

3.2.3 Turn design

Closely related to, and embedded in, both the turn-taking system and sequence organisation is turn design. That is, the way participants construct their turn in relation to the position in a sequence, the action the talk is designed to perform and the recipient (Drew, 2013). As Sacks et al (1974) report, the fact that the turn-taking system is locally managed, party-administered and interactionally controlled means that features such as turn-size and turn-order can be brought under the control of recipient design. Participants therefore design their turns to display an orientation and sensitivity to the context of the interaction. Participants also appear to design their turns to minimise conflict and promote social solidarity (Heritage, 1984b).

[9] Pre-, post- and insert expansions are built around adjacency pairs to build larger sequences of talk (Schegloff, 2007).

One area of interaction where participants can display an orientation to social solidarity is in the design of preferred and dispreferred responses. As discussed in relation to sequence organisation, first-pair parts have conditionally relevant second pair parts (Schegloff, 2007). For some first-pair parts there are, however, alternative conditionally relevant responses. An invitation or request, for example, may be accepted or declined, an assessment may be agreed or disagreed with, and a complaint may be admitted or denied. Previous conversation analytic research shows that a preference organisation exists in interaction (Pomerantz, 1984a; Pomerantz, 1984b). Actions that show social solidarity such as accepting a request/invitation, or agreeing with an assessment, are interactionally preferred. Interactionally preferred turns tend to follow immediately from the first pair part and explicitly state their agreement or acceptance[10]. In comparison, dispreferred responses tend to be delayed, are indirect and may include an account for the dispreferred response. Delays following a first-pair part including a long silence, prefaces prior to a disagreement or insertion sequences can indicate an upcoming difficulty (Pomerantz, 1984a). These delays can allow the initial speaker to revise their first-pair part, so the talk is potentially more acceptable to the recipient. In effect, this means participants can potentially avoid declinations, refusals and disagreements by amending ongoing interaction. When dispreferred actions such as declining an invitation do occur, participants may account for or mitigate their actions. These accounts- for example declining an invitation by providing an explanation as to what prevents acceptance- avoid recipients displaying a lack of willingness to accept an invitation and do not threaten the rights of participants to invite or request. In effect, even dispreferred responses often appear designed to avoid conflict and maintain social solidarity. Similarly, the issuer of a first-pair part such as a request or invitation can design the sequence

[10] While in the examples given the interactionally preferred actions are agreement and acceptance, this preference is dependent on the action being performed in the first pair part. When, for example, an assessment is performing the action of self-deprecation the preference is for disagreement (Pomerantz, 1984a)

to build in the possibility of rejection. Someone who is going to issue a request or invitation may insert a pre-expansion such as 'what are you doing this evening' or 'are you busy'. Second pair parts such as 'I'm working' or 'I'm going out' can usually avert a subsequent rejection.

Both the preliminary work speakers may do prior to actions such as requesting, complaining or inviting, and the way that recipients design their responses with delays and 'no fault' accounts[11], show how turn design is closely related to the avoidance of conflict and maintenance of social solidarity. These design features have also been associated with 'face' considerations, which Goffman (1955; 1983) proposes facilitates interaction's normative order (Heritage, 1984b; Pomerantz, 1984b). Delays potentially avert face-threatening rejections, and no faults accounts potentially minimise any 'face-threat'. Deviation from the orderly design of preferred and dispreferred responses are "morally accountable, face-threatening and sanctionable form(s) of action." (Heritage, 1984, p.268). Responding to an invitation with 'I don't want to go' or 'I don't want to go with you' would be confrontational and potentially generate conflict, or signal a desire for conflict. Turn design and its relationship to preference organisation appear to have implications for research using conversation analysis to investigate compassion in nurse-patient interaction. If compassion involves the recognition and alleviation of suffering, and a threat to 'face' potentially causes suffering, the concept of compassion may be closely related to concepts such as social solidarity and 'face'. How turns are designed could potentially prevent (or exacerbate) face-threats and suffering. As such they could be regarded as compassionate (or uncompassionate). How nurse and patient design their turns to maintain 'face' and build social solidarity are therefore possible areas for exploration.

[11] 'No fault' accounts are those where a recipient may display an inability, e.g. "I can't because…", rather than a lack of willingness (Heritage, 1984, Pomerantz, 1984a).

3.2.4 Repair

The final fundamental structure of interaction to be discussed is repair organisation. Repair organisation is essential to ensuring that when a possible trouble in speaking, hearing or understanding occurs intersubjectivity is maintained or restored, and that the turn, sequence and activity can progress to completion (Schegloff, 2007). This repair can be initiated and resolved by either the speaker or the recipient. Self-repair which occurs when the trouble-source speaker initiates and resolves a trouble with their talk, usually occurs during their turn, and can include practices such as deleting a word, searching for a word and replacing a word (Kitzinger, 2013). Self-repair can however, occur in the transition space (immediately after the speaker's turn) or in third position (Schegloff, 1997). That is, after a recipient's second-pair part, which shows that a misunderstanding has occurred, the first-speaker reformulates their talk. The recipient of a trouble-source turn can also initiate repair. This other-initiated repair can include practices such as 'huh' or 'sorry', 'wh' questions such as 'you went where?', repeats and candidate understandings such as 'you mean …' (Schegloff, Jefferson and Sacks, 1977). In comparison to self-repair, which through addressing a word or phrase in the trouble-source speaker's turn usually quickly restores intersubjectivity and progressivity, other-initiated repair creates a sequence which delays progressivity: the misunderstanding must be resolved before the interaction can continue. However, despite delaying progressivity, repair is a priority activity because, without it, intersubjectivity and the completion of actions would not be possible.

As with the organisation of preference and adjacency pair responses, there also appears to be an interactional preference involved in repair organisation. The initiation of self-repair is organisationally preferred over other-initiated repair (Schegloff, Jefferson and Sacks, 1977). Not only do self-repairs occur far more frequently than other-initiated repair, the delivery of other-initiated repair shows the organisational preference for self-repair (Schegloff, Jefferson and Sacks, 1977). When other-initiated repair occurs the recipient will tend to wait until, and just beyond, the trouble-source speaker completing their turn. i.e. there may be a gap between the trouble-source and the recipient initiating repair. These features of other-initiated repair potentially allow the trouble-source speaker to initiate and resolve the trouble source without the recipient having to expose a trouble. Other-initiated repair is therefore another area where

exploration of wider issues such as solidarity and the maintenance of 'face' is possible.

3.3 Conversation analysis, emotions and empathy

Conversation analysis's methodological approach focuses on showing what is visibly relevant to participants, through a focus on a number of fundamental structures of talk. This approach does not however, preclude the investigation of relatively abstract concepts or features such as emotions within interaction. In fact, many conversation analysts claim that using such an approach can add to our knowledge about emotions (Perakyla, 2012; Robles and Weatherall, 2021; Ruusuvuori, 2013). Rather than positioning emotions as a purely internal state, conversation analysts claim that displays of emotion, or an emotional stance can be constructed within interaction (Perakyla and Sorjonen, 2012). Emotions are therefore constructed and managed collaboratively within the interactional context, alongside other actions such as complaints and assessments. Starting from this position, conversation analysts have adopted different approaches to studying emotions. Firstly, conversation analysts have investigated emotional displays, such as crying (see Hepburn and Potter, 2012), and how participants orient to them as displaying affect. Secondly, conversation analysts have also explored how emotions are co-constructed in interaction. Surprise, for example, is not regarded as an internal state, which spontaneously emerges, but something which is co-produced within a sequence of talk. Wilkinson and Kitzinger (2006) show how a speaker will produce a turn which contains talk showing that the relevant response is surprise.

In addition to research on displays of emotion, and the construction of emotions within interaction, conversation analysts have also focused on the display or expression of empathy. Empathy is positioned as an observable phenomenon, in which the empathic person directly displays an "understanding of the thoughts, feelings, or behaviours" of the other within the interactional context (Wynn and Wynn, 2006, p.1389). Wynn and Wynn (2006) propose that empathy involves a three part sequence consisting of talk which presents an empathic opportunity, the recipient's empathic response, and finally a response from the receiver of the empathic turn. Through exploring turn-taking,

sequence organisation and turn design, conversation analysts have outlined some of the practices which display empathetic responses (Wu, 2021; Wynn and Wynn, 2006) and some of the functions of empathy in various institutional settings (for example, see Ford et al, 2019). In relation to the present study, this work shows that conversation analysis is an approach which can be used to research seemingly intangible constructs; however, the concept needs to be approached from an interactional perspective. That is, any definition to be used needs to be firmly embedded within observable talk. Accordingly, this is the approach taken in this study.

3.4 Conversation analysis and institutional talk

While conversation analysis is an approach that has now been widely used to explore interaction in a variety of institutional settings, including healthcare, its foundations are clearly rooted in everyday talk. Although Sacks' early work analysed calls to a suicide helpline, his focus was on the organisation of interaction and achievement of intersubjectivity (ten Have, 2007). Everyday talk is regarded as the "primordial form of human sociality" (Heritage 2008, p.304). As children, socialisation occurs through everyday talk, and historically everyday interaction precedes the development of complex institutions such as healthcare services (Heritage, 2009). If however, as discussed above, context is the project and product of participants' actions, institutions such as healthcare, and identities including 'nurse' and 'patient', are "built, invoked and managed" through interaction (Heritage, 2005, p.245). Researching how interaction occurs in institutional settings therefore becomes a means of identifying how institutions and roles are brought into being. That is, what in the interaction makes it an institutional encounter (Heritage, 2005). Focusing on institutional interaction can also show how external factors such as policy and training guidance are created in actual encounters (Heritage, 2005). Previous research into compassion in healthcare interaction has investigated both externally applied indicators of compassion, and the experiences and perceptions of healthcare professionals and patients regarding compassion. While there are a small number of studies, which have used conversation analysis to explore nurse-patient interaction during in-patient care (for example, see Jones, 2007, 2009; Wu, 2020), there is no evidence regarding how the policy imperative to 'act compassionately' actually occurs in naturally occurring

nurse-patient interaction. In order to understand and provide knowledge about the emergence and management of concepts such as compassion within the context of nurse-patient interaction, "an empirical baseline" (Heritage & Maynard, 2006, p.354) is necessary.

Applying a conversation analytic approach to the study of interaction in institutional settings, builds on the findings of ordinary conversation (Heritage, 2005). The same structures such as turn-taking and sequence organisation are investigated to identify what is institutional about the interaction. Comparison with previous conversation analytic work in everyday talk is therefore one method of showing how participants are orienting to the interaction as an institutional interaction (Drew and Heritage, 1992). Interaction in institutional settings will often show systematic variation and restrictions on actions and their design in comparison to ordinary talk (Drew and Heritage, 1992). For example, during medical history-taking, doctor and patient create and typically orient to the interaction as a history-taking sequence, with the doctor asking questions and the patient answering questions (Boyd and Heritage, 2006; Stivers and Heritage, 2001). In everyday talk, participants do not usually follow such a structured sequence, with people inhabiting only one interactional role. Drew and Heritage (1992) suggest that institutional talk involves three main elements which participants orient to. Firstly, that the interaction normally involves talk that is goal oriented, and at least one participant will be oriented to this. In primary care consultations, for example, general practitioners' (GPs') opening questions orient to the visit as new, follow-up or related to a chronic concern (Robinson, 2006a). Secondly, allowable talk in institutional settings is constrained. Thirdly, institutional talk may be associated with specific inferential frameworks. That is, participants may make different inferences about the practices and actions of their interactional partner in an institutional setting. For example, in everyday talk following a speakers telling of a trouble, the recipient may affiliate with the speaker's stance, showing that they agree or understand the speaker's trouble. Practices could include assessments such as 'that's terrible' (Jefferson, 1978) or the telling of a second-story[12] (Sacks, 1995). In

[12] Second stories are related stories told by the recipient of a story. In these second stories, the speaker tends to take on a similar role in the plot to that of the teller in the initial story (Sacks, 1995).

comparison, in healthcare consultations, this kind of affiliation does not always occur and this lack of affiliation is not oriented to (Ruusuvuori, 2005b).

As with the analysis of everyday interaction discussed above, analysis of institutional talk does not apply *a priori* categories. While some features of an interaction may appear relevant to the analyst, the institutional context needs to be displayed in the empirical analysis of the interaction. Through analysing organisational features of the interaction, such as turn-taking, sequence organisation, turn design and repair, the analyst can show that some feature of the context is consequential to the interaction (Schegloff, 1992). As Schegloff (1992) states, the analyst has first to show that the practice is relevant and procedurally consequential, but the analyst then has to ascertain what the talk reveals about recipient design and orientation to context. Through this final stage the researcher can identify the institutional practices, actions, stances, ideologies and identities which are being enacted (Heritage, 2005). In the present research, using the definition of compassion developed in chapter 1 (see definition, p.50), this process would involve identifying practices that nurse and patient orient to in specific micro-interactional contexts. Following the identification of practices, the design and consequences of these practices can be explored, in order to begin building an empirical account regarding the enactment of compassion in nurse-patient interaction.

As discussed above, the organisational features of interaction which show that participants orient to the interaction as an institutional encounter cannot be determined *a priori*. However, previous research suggests that the significance of different organising features of interaction varies according to the institution. In some formal settings, such as courtrooms, there may be distinctive patterns of turn-taking organisation (Atkinson and Drew, 1979), however, in healthcare settings turn-taking organisation may be less formal, with the boundaries between institutional and everyday talk less certain (Drew and Heritage, 1992). In settings such as healthcare, Drew and Heritage (1992) suggest that the institutional nature of the interaction is often evidenced in the organisation of sequences and turn-design. Certainly, in previous conversation analytic research in healthcare, sequence organisation and turn design appear to be important components. One example of the importance of turn design and sequence organisation, and of possible relevance to the present study, is

Ruusuvuori's (2005a; 2005b; 2007) research focusing on empathy and sympathy in GP and homeopathic consultations. While in everyday talk, recipient affiliation with a speaker's troubles-telling is not uncommon (Jefferson, 1988), in GP, and homeopathic consultations to a lesser degree, patient's troubles are usually receipted with a minimal acknowledgement, silence and/or continuation of the task. The design of responses and subsequent sequences suggest that this lack of affiliation is not an accountable action. That is, participants do not indicate that any rule has been breached. Instead both the professional and patient orient to the encounters as institutional problem-solving or service encounters. However, Ruusuvuori (2005a) suggests that this orientation to a service encounter may be problematic in homeopathic consultations, where a focus on healing and holistic care means service delivery requires an extended narrative. While homeopathic practitioners orient to this extended narrative, commencing consultations with an open-question, patients often presented a problem rather than an extended narrative. Ruusuvuori (2005a) suggests that this mismatch between the aims of homeopathy consultations and patients' orientations related to patients responding to the norms of the service encounter, which involve providing information or a problem presentation. The work of Ruusuvuori provides a good example of how conversation analysis can be used to show what participants actually orient to in an institutional setting, and to show variations between different healthcare settings. i.e. that the contingencies in homeopathy are different to GP consultations. While conversation analytic work in areas such as primary care is extensive (Gill and Roberts, 2013), interaction in nurse-patient interaction is underexplored. The contingencies within nurse-patient interaction, including space to acknowledge and respond to suffering may be different to in primary care. In relation to the enactment of compassion, conversation analysis therefore provides an approach, which can explore both how a concept such as compassion is enacted and the institutional norms participants actually orient to in nurse-patient interaction.

3.5 Conclusion

The present chapter has presented conversation analysis as an approach to investigating how compassion is enacted in nurse-patient interaction. With foundations in Goffman's (1983) interactional order and Garfinkel's (1984) ethnomethodology, conversation analysis focuses on the practices people use to

achieve intersubjectivity (Clayman and Gill, 2004). Conversation analysis avoids the application of external criteria about what constitutes compassionate behaviours, as may occur with an observational checklist. The conversation analytic approach also avoids the assumption that what participants say occurs, corresponds with what actually occurs within the interactional context. Instead, conversation analysis uses audio-visual recordings, repeated observation and detailed transcription to investigate how participants achieve intersubjectivity. In the next chapter, I will detail how the conversation analytic approach was used for this specific study.

Chapter 4 Methods

4.1 Introduction

As discussed within the literature review, research exploring healthcare professionals' and patients' perceptions and experiences of compassion identifies interaction as an important component. A variety of different interactional features are conceptualised as displaying compassion (Figure 2.2, p.36). There is however, a gap in knowledge regarding how compassion is actually enacted within its interactional context. Within the methodology chapter, I presented conversation analysis as an approach to exploring the enactment of compassion within its interactional context. In the present chapter, I will discuss the methods used to complete this conversation analytic study. I will describe the collection and analysis of audio-visual recordings of interactions between advanced clinical practitioners (ACPs) and older patients in healthcare of the older person wards and bed-based reablement. This will include describing the design of the research, the context and sample, the ethical considerations involved in collecting audio-visual recordings in acute hospital settings, recruitment, collecting recordings and the process of analysis. First, I will outline preliminary work completed to finalise the research design and facilitate the collection of audio-visual recordings in acute hospital settings.

4.2 Pre-data collection activities

When designing and conducting healthcare research, collaboration with key stakeholders assists in the development of research that is acceptable and of value to patients and healthcare services (National Institute for Health Research, 2021; Staley, 2009). In relation to the proposed study, stakeholder involvement was particularly important for ensuring that quality recordings could be obtained in an acceptable and safe way, and which minimised disruption in busy healthcare settings. Based on the use of video-recording in physiotherapy and palliative care settings, Parry et al (2016) reflect that compared to other data collection methods, people are less familiar with this approach. Certainly in relation to nursing care in acute hospital settings, there are few reported studies that collect and analyse audio-visual recordings using conversation analysis (See Harwood et al, 2018, for example). Preparatory

work therefore involved consultation with both service users and healthcare providers, and time spent with both ACPs and staff on healthcare of the older person wards.

4.2.1 Healthcare provider involvement and site preparation

The research was a joint project between the University of Nottingham (UoN), and a large teaching hospital with a commitment to research by nurses and allied health professionals (AHPs). A member of the supervisory team is a senior nurse in the hospital and acted as a gatekeeper, initiating introductions with ACPs and senior staff. I also obtained an honorary contract with the hospital, which allowed me to attend hospital meetings and shadow staff while developing the research protocol. Senior nursing staff met during the preparatory phase of the project responded positively to the project, confirming the relevance of the topic, and that healthcare of the older person wards (HCOP) would be a good location to complete the research.

I first attended ACP staff meetings in November 2017. Although a nurse with experience working in hospital settings, I had not worked with ACPs, or been an employee in the hospital where the research was to be conducted. Attending ACP staff meetings allowed me to outline the project, obtain input from ACPs in the development of the project, and develop an understanding of their role. Following attendance at staff meetings, I shadowed a number of ACPs, with their agreement, in order to understand how they worked in different areas, and whether the study was achievable. Undertaking ethnographic observation or prolonged presence in the healthcare setting prior to the collection of video-recordings assists in building trust, and understanding the work environment and how recording can be undertaken safely (Caldwell and Atwal, 2005). As such, a period of preparatory observation is considered good practice (Parry *et al.*, 2016). As will be discussed below, this preliminary work directly influenced decisions regarding the location of data collection.

In initial meetings, ACPs had identified that their principal role was to complete the comprehensive geriatric assessment. The comprehensive geriatric assessment is a multi-disciplinary evaluation and management plan, which

focuses on medical, functional, social and environmental issues, for the frail, older person (Welsh, Gordon and Gladman, 2014). However, ACPs identified that how this assessment was performed, and their role in it, depended on the location they were working in. ACPs specialising in HCOP worked in three areas:- Accident & Emergency (A&E), HCOP wards and a reablement unit. Although the preliminary proposal had been to collect data on HCOP wards, shadowing allowed the researcher to consider all ACP work locations for data collection. While shadowing showed that data collection would be possible on HCOP wards, some ACPs did limited shifts on the wards due to service-level agreements with A&E and a community reablement unit. From these observations, it was clear that in order to obtain an adequate number of recordings, data needed to be collected in additional locations. Shadowing and consultation with ACPs suggested that A&E would not be an appropriate location to complete the research. There were concerns about obtaining consent from often frail, older patients during emergency attendances, particularly when the research could be undertaken in other locations. Additionally, the HCOP ACP's role in the A&E frailty unit was relatively new, there was pressure to show the value of their role in A&E, and some ACPs acknowledged that they found this setting stressful. There was therefore concern regarding ACP participation in data collection in A&E. In comparison to A&E, ACPs working at the reablement unit spoke positively about their established role in this setting. The reablement unit, in this case, was a wing of a care home, which provided care to those with ongoing medical needs who no longer needed to be in hospital but who required ongoing assessments, or whose discharge was complex. Patients stayed in the reablement unit for approximately six weeks, meaning there would be time for recruitment and consent. The ACPs' role in the reablement unit involved assessing patients weekly, and responding to any new medical concerns. Observations suggested that these assessments lasted twenty to thirty minutes, and would provide a safe, acceptable location to collect audio-visual recordings.

4.2.2 Consultation/Public and Patient Involvement

Public-patient involvement (PPI) is regarded as integral to high quality, relevant healthcare research (National Institute for Health Research, 2021). There is however, increasing recognition that ethical PPI should involve participant remuneration (INVOLVE, 2010). As a PhD project, PPI remuneration was not available, therefore having PPI representatives involved consistently throughout the project was not possible. The proposed objectives and design were

however, presented to members of the UoN Dementia, Frail Older Persons and Palliative Care Patient and Public Advisory Group. There was a consensus that compassion was an important component of healthcare communication and that recording nurse-patient interaction would be an appropriate method. There were some discussions about study settings, with some suggesting the addition of palliative care settings. With the time and resources available for a PhD project, all suggestions could not feasibly be included in the research design. Two members of this group also reviewed patient information sheets (Appendix 9), patient consent (Appendix 10) and post-recording authorisation forms (Appendix 11). The input of the PPI group also led to the development of a participant summary booklet (Appendix 12), developed to assist with accessibility to the study, for those who may have the early stages of dementia or other conditions that may impair cognition. As agreed, I plan to share findings with ACPs and the Dementia, Frail Older Persons and Palliative Care Patient and Public Advisory Group. I also plan to seek the advice of both groups regarding the development of training materials, which result from this thesis.

4.3 Research Design

4.3.1 Aim

To produce detailed knowledge about the structure and functioning of communication practices associated with compassion, which occur during interactions between advanced clinical practitioners (ACPs) and older patients.

4.3.2 Objectives

-To explore how conversation analysis can be used to identify compassionate actions.

-To explore how compassion is enacted in interactions between ACPs and older people.

-To identify the structure and functioning of communication practices used by ACPs.

4.4 Sample

Conversation analysis adopts a 'specimen approach' to sampling. That is, the reality is directly observable in the data, as opposed to the data representing a reality that is not directly observable (ten Have, 2007). Analysis occurs in terms of category, in this study compassion, rather than the population. Data to examine compassion could therefore potentially have been collected in any healthcare setting, with any healthcare staff. However, as will be outlined, review of the literature on compassion provided good reasons for exploring compassion in the interaction between ACPs and older hospitalised patients.

4.4.1 Healthcare Staff – Advanced clinical practitioners

While compassion is recognised as an important component of all healthcare practice (Francis, 2013a; Parliamentary and Health Service Ombudsman, 2011), it has been particularly associated with nursing practice. Compassion in Practice (Commissioning Board Chief Nursing Officer and DH Chief Nursing Adviser, 2012) is a policy specifically focusing on nursing practice that, followed the Francis Report (2010), and as shown in Table 2.2 (p.24), research exploring compassion in healthcare has predominantly focused on nursing. Focusing on nursing interaction therefore appeared relevant to professional and policy discourse regarding compassion. As discussed in section 2.4.2 (p.15) there are also competing and, at times, contradictory relationships between technical care and compassion in policy. Policy states that compassion and technical care are inseparable, but also suggests that technical care should be prioritised (Parliamentary and Health Service Ombudsman, 2011). Collecting recordings of staff who were technically proficient was therefore important. As experienced healthcare professionals, who had undergone additional training to demonstrate "core capabilities and area specific clinical competence" (Health Education England, 2017, p.8) ACPs appeared to fulfil this requirement.

Only ACPs who had been registered nurses for more than five years were included in the sample[13]. Although to some degree arbitrary, designating a length of time since qualification was intended to obtain technically skilled nurses. In order to maximise recruitment, both qualified ACPs specialising in HCOP, and those who had reached the independent practice stage of training were eligible for inclusion.[14]. The inclusion criteria (Table 4.1) gave an eligible ACP population of eight. In order to obtain an adequate sample, ACPs were eligible to participate in up to ten recorded consultations.

4.4.2 Patients

As Table 4.1 below shows, patients eligible for inclusion were older (over the age of 65). Estimates suggest that people aged over sixty-five account for 62% of hospital bed days (National Audit Office, 2016). Hospital care therefore increasingly focuses on older people. In addition, reports into care failures have predominantly involved older people, especially those who are frail (see Francis, 2010, 2013a; Parliamentary Health Service Ombudsmen, 2011, The Patients Association, 2009). Exploring the enactment of compassion within the older population, where reports have identified failings would be timely, and assist in the identification of skilled practice. As HCOP wards in the participating hospital, and the reablement unit, admitted those with multi-morbidity and frailty[15] over the age of sixty-five, they provided the most appropriate context in which to conduct the research.

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[13] ACPs can also have a background in other allied health professions, such as physiotherapy (Health Education England, 2017). At the time data was collected, all HCOP ACPs in the hospital were qualified nurses.

[14] ACPs who have successfully competed years 1-2 of the MSc advanced practice work independently as an ACP.

[15] Frailty is a clinically recognised state of vulnerability resulting from a decline in the body's physical and psychological reserves, which is associated with ageing (British Geriatric Society, 2018).

Table 4.1 Participant inclusion and exclusion criteria

Inclusion

Healthcare Staff

- Qualified ACP or an ACP who has completed the practical element (years 1-2) of the MSc Advanced Practice.
- Working in Healthcare of Older People.
- Registered nurse qualified >3 years.

Patients

- Age 65 years or above (no upper age limit).
- Patient seeing an ACP participating in the research.
- Currently or newly admitted to a ward specialising in Healthcare of Older People or a community reablement unit.
- Assessed by clinical team as able to participate without causing undue mental and physical distress.
- Capacity to give informed consent or, if assessed as lacking capacity to give informed consent, a personal consultee is available who can provide advice regarding whether the patient would wish to participate.

Companions

- Relative, friend or unpaid carer.
- Present during the interaction between the ACP and older person.

Other healthcare professionals and students

- Present in the interaction between the ACP and older person.

Exclusion

Patients

- Assessed by the clinical team to be experiencing severe distress or a medical emergency.
- The patient has been assessed by clinicians as at the end of life (i.e. death is expected within one week).
- Patient (or companion) requires a translator for the care encounter.

Exclusion criteria included patients experiencing severe distress, medical emergencies, or where clinicians assessed the patient as at the end of life. These exclusion criteria were implemented to ensure that potentially vulnerable patients were protected from harm. Included in the eligibility criteria were patients with capacity to give consent, as well as those where the patient was assessed as lacking capacity to consent, but a personal consultee was available who could provide advice regarding the patient's wishes. While the Mental Capacity Act states that there must be 'reasonable grounds' for believing that comparable research cannot be confined to only those who have capacity to give consent (section 31:4, Mental Capacity Act, 2005), there is also a recognition that excluding those who lack capacity is "an affront to their dignity" (Hellstrom, 2007, p.609). Additionally, members of a PPI group, which included both carers of and those living with dementia, actively encouraged the inclusion of those who may lack capacity to give consent in the study.

With regard to patients, the researcher proposed recording up to three consultations per patient. These figures accounted for the fact that some patients would be too unwell or distressed to participate, some would not want to be involved, and that some people willing to participate would have protracted hospital admissions. Decisions about how many recordings per participant therefore aimed to balance the need for an adequate number of recordings, a variety of recordings involving different ACP-patient dyads, and conducting the research without creating an additional burden for participants.

4.5 Ethical Considerations

The research adhered to the UoN Code of Research Conduct and Research Ethics (2016), the National Institute for Health and Care Research (NIHR) principles for Good Clinical Practice (GCP) (2022), the UK Policy Framework for Health and Social Care Research (2017) and, as a nurse, the NMC code of professional conduct (2015). As the research involved NHS patients and staff, a formal review of the study's ethical integrity was completed by the Yorkshire & Humber – Bradford Leeds Research Ethics Committee (REC ref: 19/YH/0012), and approval was given by the Health Research Authority (see Appendix 13 and Appendix 14 for authorisation letters). The UoN acted as sponsor and provided public liability insurance for the present research.

While the ethical issues associated with research using video-recordings are no different to other studies, the way they are manifested varies (Broyles, Tate and Happ, 2008). For example, video-recording increases participant identifiability, therefore participants need to be informed how their data will be securely stored, and given the opportunity to decide under what circumstances the recording can be used (Parry *et al.*, 2016). With regards to procedures for the recruitment, consent, collection and storage of audio-visual recordings, guidance from the General Medical Council (2011), National Centre for Research Methods and ESRC (Jewitt, 2012) was adhered to. A Data Protection Impact Assessment (DPIA) was also completed to ensure that the study complied with the General Data Protection Regulations (GDPR). The DPIA assessed the risks to participants' rights to privacy of collecting and storing audio-visual recordings, and how these risks would be mitigated. Mitigations included ensuring that participants were informed about how their data would be stored, under what circumstances it would be shared, and that participants were able to give informed consent.

I adopted a number of procedures to protect participants and health services from potential harm and disruption, and to ensure informed consent and confidentiality throughout the research process (See Appendix 15 for a summary of ethical issues addressed). Adherence to regulatory procedural governance is however, only one element of research ethics. Qualitative research also involves a process of 'micro-ethics' where the researcher addresses emerging ethical issues and makes decisions in the field (Pollock, 2012). Specific emerging ethical issues encountered during the research process are discussed throughout the methods.

4.6 Access

As the research was to be conducted across two sites, letters of access were obtained from two NHS Research & Development Units:-

i) the Research & Development Unit in the teaching hospital where ACPs were employed and HCOP wards were located.

ii) the Research and Evidence Department in a Community Trust, who provided letters of access for the reablement unit.

However, there were some issues in obtaining access to the reablement unit, despite the fact that care home managers and the Research and Evidence Department had been engaged in the planning of the research. The primary care trust that commissioned the service also wanted to ensure that there was capacity and capability in the reablement unit to complete the research. The primary care trust's governance procedures also required the completion of their own DPIA, which was completed by another organisation. Fragmentation of services created delays gaining access, both with regards to which organisations were commissioned to provide which services, i.e. reablement services being commissioned by the primary care trust and ACPs being employed by the hospital trust, and the fragmentation of research and governance procedures, i.e. the primary care trust's research governance and data protection officer being commissioned. Following gaining ethical approval at the end of March 2019, formal research access for the reablement unit was not obtained until October 2019. As will be discussed in the summary of data collection (Section 4.9 p.94), changes in the provision of medical care to the reablement unit, and withdrawal of ACPs in November 2019, limited data collection at this site.

4.7 Recruitment

4.7.1 Advanced clinical practitioners

A lead nurse in the hospital initially sent an email to eligible ACPs informing them that the study had obtained ethical approval, and that recruitment had commenced. The email also contained an ACP participant information sheet (PIS) (see Appendix 10 for example of patient PIS)[16]. Following this email, ACPs were directly approached during ward observations by the researcher. Where ACPs expressed an interest, the researcher fully explained the study and

[16] Participant information sheets and consent forms varied depending on the participant's role. That is, there were different participant information sheets for ACPs, patients, patient's companions and other professionals who may be involved in a consultation.

provided a participant information sheet. On the ACPs next shift (usually the next day), ACPs agreeing to participate completed a written consent form.

Researchers need to be aware of relationships between gatekeepers and participants, to ensure that participation is free from coercion (Davies, 2008). To mitigate these potential concerns, I made clear that participation was voluntary throughout preparatory work, and during recruitment conversations. Four of eight eligible ACPs participated in the study, suggesting that recruitment was voluntary. In line with GCP Guidelines for conducting research (National Institute for Health and Care Research, 2022), I did not seek reasons for non-participation; however, a number of ACPs did provide reasons. These reasons included not being comfortable with recording and workload pressures. Individual ACPs also made decisions about their level of participation. One ACP, for example, consented to participation, but decided only to participate in recordings in the reablement unit as this was where they regularly worked and felt particularly confident in their practice. As ACPs determined which patients should be approached regarding recruitment, they also had some control over which interactions were recorded. On occasion, recording of an ACP-patient consultation did not occur at the ACP's request due to workload pressures, for example, a patient becoming critically ill or a large number of admissions. These factors suggest that ACP participation was voluntary and that they were able to participate to the extent that they felt comfortable.

4.7.2 Patients

In order to reduce harm and potential intrusion, recruitment of patients occurred in two stages (Figure 4.1). Firstly, a member of the usual care team would approach the patient to ask if they were willing to speak to the researcher about possible participation. Staff approaching patients were provided with a guide to inviting eligible patients to speak to the researcher about participation (see Appendix 16). This guide encouraged staff approaching eligible participants to acknowledge that this may be a difficult time for patients (and their companions), and encourage those experiencing difficulties to decline participation. If agreeable, the researcher then met with the patient to provide further information about the study.

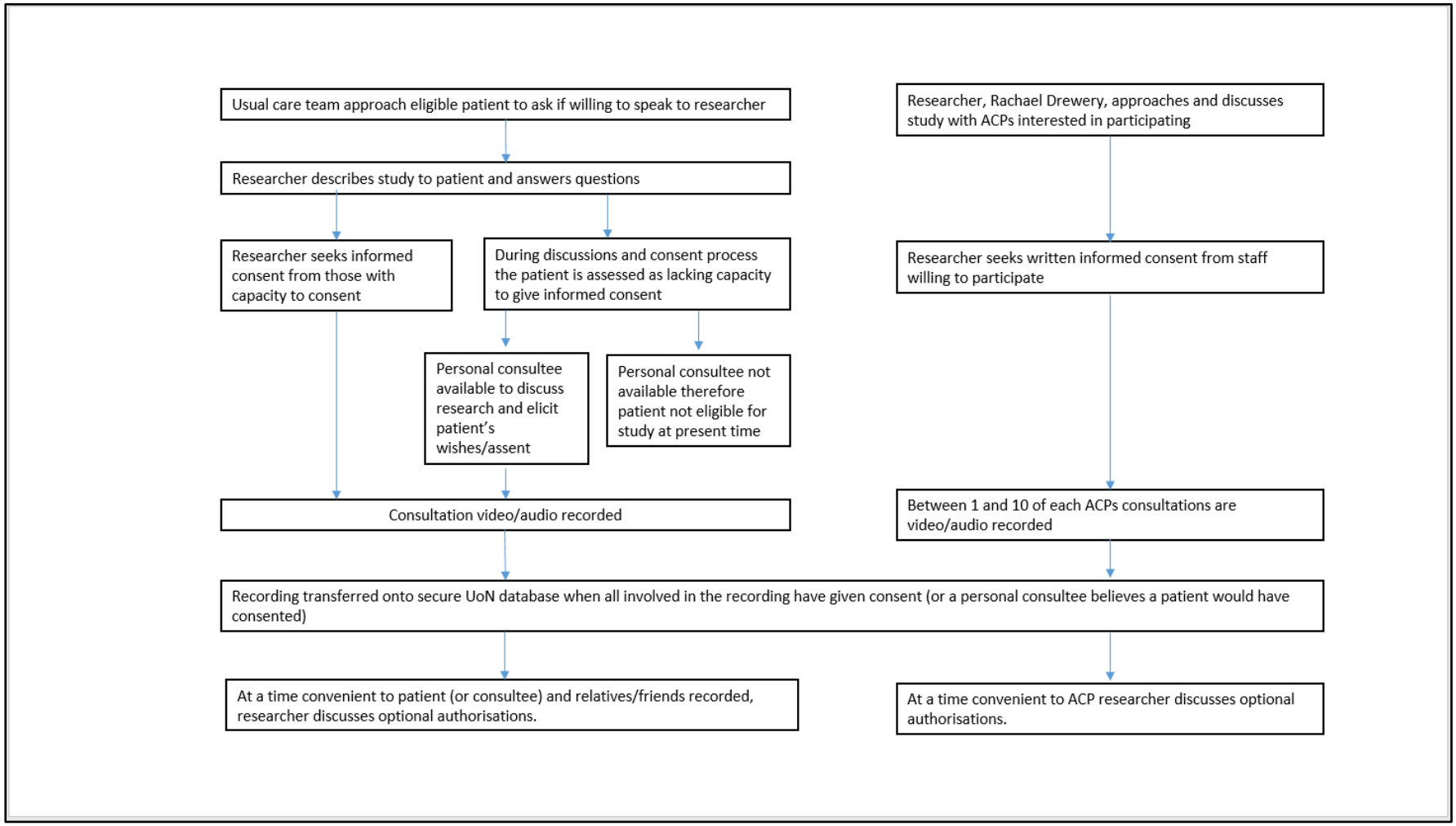

Figure 4.1 Study Schematic

Due to the number of locations where ACPs worked during the six months of data collection, the regularity with which other staff caring for patients changed, and other staff's workload capacity, ACPs predominantly undertook these initial patient conversations about potential participation. Five of these initial conversations were completed by other staff. The selection of participants by gatekeepers is criticised for introducing selection bias, and in some qualitative research gatekeepers can influence whose voices are heard (Oye, Sorensen and Glasdam, 2016). ACPs may have selected patients where they believed they could display compassion. However, as conversation analysis prioritises a 'specimen approach' rather than a 'representative sample', ACP selection of potential patient participants raises less methodological issues. In fact, a degree of self-selection by ACPs may have had a number of advantages. Firstly, ACPs' prior knowledge of potential participants meant that patients who were acutely unwell, or patients where there were concerns that the study may cause distress, were not approached about study participation. Secondly, the ability of ACPs to determine which patients should be approached about participation, provided ACPs with some control over which interactions were recorded, and reduced the risk of pressure to record consultations they were not comfortable with.

Patients who agreed to speak to me about participation were then approached regarding the study. During these conversations I introduced myself, and briefly explained the study and what participation would involve. Patients who displayed an interest in participating were provided with the participant information sheet and summary booklet, and decisions were made in conjunction with the patient about the most convenient time to provide further information. Some patients were willing to talk fully about the research study and participation at the first recruitment conversation. In other instances, I was asked to return at a different time of the day when the patient felt more alert or when a family member was present. The majority of those recruited were frail, had a number of concurrent medical problems, and were not in their usual surroundings. Some were experiencing intermittent delirium, and many had sight, hearing and mobility issues. In conjunction with the study summary booklet, the use of plain language and visual aids such as recording equipment, finding the right time to discuss participation, and providing information over two or three conversations where requested, was essential to ensuring informed

consent, maximising opportunities for participation, and ensuring that patients were not overburdened at a potentially stressful time.

While patient recruitment started from the assumption that all participants had capacity to give consent, during some recruitment conversations it became clear that, despite strategies to ensure patients could consent to participation, the patient could not understand, retain, weigh up or communicate a decision regarding participation (Mental Capacity Act, 2005). Where the patient was assessed as not having capacity to give consent, and a consultee was available and willing, the consultee's opinion was sought regarding the patient's wishes about participation and whether the patient should take part. If, following these conversations and the provision of written information, the consultee believed the patient would want to participate in the study they completed a consultee declaration form. In the two instances where the patient lacked capacity to give consent, the patient was shown the recording equipment and assent was sought to undertake the recording. Through these processes the personhood and wishes of the patient unable to give consent were taken into consideration (Hellström *et al.*, 2007).

4.7.3 Patient companions and/or healthcare staff and students accompanying ACPs

While the research addresses compassion in ACP-patient interaction, collecting audio-visual recordings within context meant that there was the potential for patient's companions, and other healthcare staff and students to be present during recorded consultations. Recruitment and consent issues for these participants therefore also needed to be addressed. Where a companion was present the same procedures as already outlined for patients were followed. As the study specifically concerned ACPs, healthcare staff and students accompanying the ACP were informed that their communication would not be subject to analysis. They were however, informed that their communication may be included in transcripts, and they may be audible/visible during recordings. Again, the study was discussed with staff and students accompanying the ACP prior to recording, and informed consent was obtained, using a participant information sheet and a consent form adapted specifically for this group of participants.

4.7.4 Informed consent

Following GCP guidelines and the agreed protocol ACPs, patients with capacity to give consent, and any companions or additional healthcare professionals who were going to be present, gave written consent prior to the first recorded consultation. In addition to written consent, ongoing consent was checked before the actual recording. Occasionally, patients decided on the day of recording that they no longer wanted to participate (n.1). In addition, some patients felt too unwell to participate on the day of recording and data collection was postponed (n.3). As the protocol permitted the recording of multiple consultations from participants, up to ten for ACPs and three for patients, ongoing consent was checked prior to any subsequent recordings.

Informed consent for all participants involved a two-stage process. In addition to obtaining consent to record, store and analyse the recording of the consultation prior to data collection, separate post-recording authorisation was used to discuss further, related uses for the recording (see Appendix 11 for post-recording authorisation form). A long-term objective of the research is to provide evidence for use in communication skills training. Using episodes of actual interaction as they occurred in real-time is a method for overcoming the artificial nature of simulated or hypothetical encounters, when compared with actual practice (Stokoe, 2014). The post-recording authorisation therefore included use of extracts from the recording (with place and person names erased, but with physical and voice features intact) in data sessions, presentations to other researchers and communication skills training. The authorisation also asked about use in future research. Permission to use the data in future research reduces the burden on health services and future participants, and is economical (Corti *et al.*, 2014). Using post-recording authorisations in the present study had a number of benefits. As acknowledged in the literature, participants do not have detailed knowledge of what will happen in a consultation until after the event (Parry *et al.*, 2016). As a result, participants cannot know what will be captured on camera and what exactly they are consenting to. Participants can therefore not make fully informed decisions about the sharing of data until after the event. Additionally, the optional authorisations take time to explain and increase the volume of information to be given to busy healthcare staff and, often frail, unwell older

patients prior to recording. Following recording, where participants agreed, time was therefore provided to show participants the recording and consider how the data may be used in the future.

An important part of the Mental Capacity Act (2005) is maximising the ability of a person with a cognitive impairment to give informed consent. The two-stage consent process assisted with this process. Discussing optional authorisations following discharge allowed time for patients to recover. A good example of this is a patient who had been experiencing intermittent delirium. There were no concerns about the patient's ability to give consent, when initial consent was obtained. When I came to discuss optional authorisations, the patient had difficulty understanding possible consequences of storing data in an external archive (see point G-H of the optional authorisation, Appendix 11). Rather than pursue the optional authorisations, it was agreed that I would contact the patient following discharge. Completing these optional authorisations at a later date, allowed time for the patient's delirium to resolve and for them to fully understand what the optional authorisations entailed, rather than pursuing the advice of a consultee.

4.8 Process of data collection

Depending on the consent of participants, audio-visual or audio-only recordings of ACP-patient consultations were collected. Use of audio-visual recordings are ideal because they capture embodied communication practices and the physical activities involved in patient care (Mondada, 2013). However, there is limited research regarding the acceptability of collecting audio-visual recordings of consultations in hospital settings (Parry *et al.*, 2016). While research in other healthcare settings suggests that stakeholders predominantly view video-based research as acceptable and valuable (Pino *et al.*, 2017; Themessl-Huber *et al.*, 2008), in research exploring stakeholders' views on the acceptability of video-recording in hospice consultations, a small number of patient participants raised concerns about being recorded, particularly if their appearance had changed (Pino *et al.*, 2017). PPI members also suggested that providing an option to collect audio-only recordings of consultations may increase participation. While the collection of audio-visual recordings is ideal for conversation analysis, audio-only recordings provide a "good enough" record of what happened for analysis

(Sacks, 1984, p.26). In order to achieve a balance between the amount of data collected and the quality of data, participants were therefore able to consent to just audio-recordings. Thirty-seven percent (n.10) of recordings collected were audio-only.

As discussed in the methodology, the collection of 'naturally occurring data', which represents the interaction as accurately as possible, is a key feature of conversation analysis (Clayman and Gill, 2004; ten Have, 2007). The recordings also need to be of a good enough quality to ensure that the detailed analysis of verbal and embodied content can be conducted (Parry, 2010; ten Have, 2007). In busy, frequently noisy hospital settings, there was however, a balance between collecting naturally occurring data, and generating recordings of a good enough quality to ensure the detailed analysis of verbal content and, where video-recorded, analysis of embodied features. Preparatory work had highlighted that patients did orientate to the researcher, particularly non-verbally during ACP consultations. I was also aware that having a researcher present during a consultation is not usual; therefore, I set up recording equipment and left the consultation either prior to, or just as the consultation started. Leaving the consultation did however, mean that I could not control the video-recorder's position or ensure that it was working correctly. To overcome these potential concerns about quality, at least two devices were used for each recorded consultation.

In addition to a combination of a small GoPro camera and a larger wide-angle lensed camera, a digital audio-recorder was used to collect data. As the internal microphones on video-cameras can be inadequate where background noise is present, the addition of a digital audio recorder was used to increase the quality of audio-data collected and provide audio- back-up should cameras fail (Parry, 2010). Following the first two recordings, a lapel microphone was also obtained and used where participants agreed. HCOP wards are dynamic, noisy environments and some patients were quietly spoken. While, where possible, radios on the ward were turned off prior to recording, and on one occasion a fan, I attempted not to interfere with the usual environment excessively. Noise from other patients and staff, pressure-relieving beds and oxygen remained. The lapel microphone helped cut out some of this background noise, and increase the verbal details available for analysis.

The positioning of cameras varied according to the space and positioning of the patient, for example, whether the recording occurred in a bay or side room, and whether the patient was in bed or a chair. However, frequently a small GoPro camera on a tripod was placed on the end of the patient's table and then a larger wide-angle lensed camera was placed just inside the patient's curtains. Good practice guidelines for recording healthcare consultations recommend making equipment as unobtrusive as possible (Parry et al., 2016). Due to the limited space once the curtains were around the patient's bedside and the usual positions of participants during consultations[17], there were difficulties making cameras unobtrusive at a patient's bedside. Following obtaining a lapel microphone, the decision was taken to only use the smaller GoPro camera on the table, as the picture and sound quality from these cameras, when a lapel microphone was attached, were adequate for transcription and analysis. While the GoPro camera was close to the ACP and patient, its size meant that it was relatively unobtrusive. Due to the failure of the lapel microphone during the tenth recording, and a combination of time limits on data collection and difficulties obtaining a new lapel microphone, both cameras were used for subsequent recordings.

While research evidence suggests that recording is unlikely to impact on healthcare consultations (Parry et al, 2016, Themessl-Huber et al, 2008), all participants were advised that if they thought this was the case the ACP could stop the recording. Participants were also informed that cameras would be stopped, and privacy maintained if any intimate care was required. ACPs were shown how to turn recording equipment off, and the researcher remained in the vicinity, so the recording could be turned off quickly if necessary. In one consultation, the ACP did turn off the camera to complete an examination. Finally, procedures were implemented to ensure that the rights of other people

[17] When the patient was sat in a chair, the ACP usually sat on the bed. When the patient was in bed, the ACP either sat on a chair next to the patient, or crouched/stood at the side of the patient's bed. These configurations meant that, to avoid recording the back of the ACP or patient, cameras could often only be placed on one side of the bed.

on the ward were maintained. Signs were put on the door/curtains where the recording was occurring and the researcher's presence in the vicinity meant staff could be informed and encouraged not to enter the bed space where a recorded consultation was occurring. During one audio-recording a member of staff did enter a consultation where recording was occurring. In this instance, procedures for obtaining informed consent from the staff member were obtained retrospectively.

In addition to the recordings, the researcher also made brief observational notes during data collection. These notes included, if known, any specific conversations that were planned during the consultation, e.g. discharge or the results of a test, and general details about the volume of work and the ward e.g. if an ACP was caring for a large number of patients or had critically-ill patients. While these observational notes were not formally analysed, background information about the setting and the activities occurring can help inform analysis (Maynard, 1984).

4.9 Summary of data collected

Between June and December 2019, twenty-seven audio-visual recordings of ACP-patient interaction were collected from three acute HCOP wards, a community reablement unit and a hospital reablement unit. Due to the ACPs recruited being predominantly based on one ward, the majority of recordings are from one ward (n.20) (Table 4.2). A number of external factors impacted on data collection. Data collection had to be suspended for over two weeks, as HCOP wards implemented infection control procedures to prevent the transmission of norovirus. During the period of data collection, staff rotation meant the wards ACPs were working on changed twice. These rotations meant that ACPs, and the researcher had to adapt to the slightly different working procedures on each ward, for example, whether ACPs were managing a bay of patients or a consultant's patients. The most significant factor affecting data collection was however, a change in the services that ACPs were commissioned to provide. As already mentioned in section 4.6 (p.84), the number of agencies involved in granting access to the community reablement unit resulted in a delay gaining access. Following an ACP leaving the organisation, and the commissioning of ACPs to staff a hospital reablement unit, the services of ACPs

were withdrawn from the community reablement unit at the end of November 2019. This combination of delays in obtaining access and service changes meant that only one recording was obtained from the community reablement unit.

Table 4.2 Summary of data collection

	No.
Recruitment	
Patients approached by researcher	47
Patients consented to participate	27
Patients recorded	23
Locations of data collection (n.27)	
Ward A	4
Ward B	20
Ward C	1
Community reablement	1
Hospital reablement	1
Type of data collected (n.27)	
Audio-visual recording	17
Audio recording	10
No. recordings per patient (n.23)	
1	20
2	2
3	1
Age of patient participants (n.23)	
<70	1
70-79	5
80-89	9
90-99	8

Continued.

Table 4.2 Summary of data collection (continued)

Reason for admission (n.23)	
Infection	8
Fall/collapse	10
Heart failure	2
Other	3

In total, the researcher discussed the study with forty-seven patients, of which twenty-seven consented to participate in the study. While patients were not asked their reasons for not participating, where reasons were given these generally related to either not wanting to be seen or heard on camera (particularly while unwell) or being too ill or old. Ultimately, the twenty-seven recordings are derived from consultations between four ACPs and twenty-three patients. One patient changed their mind about participation and three patients were transferred to another ward or discharged before the next ACP-patient consultation[18]. The number of recordings collected from individual ACPs ranged from one to ten, and between one and three from patients, although the majority of patients participated only once. As the summary of recorded consultations (Table 4.2) shows the patients varied in age and reason for admission. The majority of consultations involved an assessment (in two cases the purpose of the consultation was to cannulate the patient, although one of these also included concurrent assessment). There were however, variations in the focus of the assessment, depending on the diagnosis, the patient's current problems and where the patient was in their hospital stay. Due to the acuity of newly admitted patients, and eligibility criteria, in all but two recordings the ACP and patient had previously met. As patients were generally towards the end of their hospital stay, a significant proportion of consultations focused on discharge.

[18] These transfers generally occurred overnight or outside normal working hours to allow for admission of new patients.

At the end of December 2019 the decision was taken not to extend the length of data collection and obtain more recordings. Conversation analysis focuses on the detail of the data rather than quantity (Sacks, 1995). Sacks (1995) claims that one data source is adequate to display interactional practices and conversation analysis research does include single cases (for example, see Toerien & Kitzinger, 2007). Small sample sizes are therefore justified in conversation analysis. However, enough data is required to identify interactional patterns and variations in these interactional patterns (Perakyla, 2004). There is also a need to increase trustworthiness and guard against what Drew et al (2001) describe as the "idiosyncratic styles" of individual practitioners (p.60). With twenty seven audio-visual recordings, a total of five hours seventeen minutes (range four minutes to twenty-seven minutes) of data had been collected from a variety of ACP-patient dyads. This amount of data was adequate to explore compassion within the dataset, within the remaining period of a PhD study.

4.10 Data analysis

Following collection of a recording, I transferred the data onto UoN OneDrive and deleted it from the recording devices to ensure safe storage and participant confidentiality (see Appendix 15 for further details of confidentiality and safe storage post-recording). I also viewed the data, wrote a synopsis of the consultation, and documented any details of immediate interest. An orthographic transcription of each recording was then completed, using the best quality recording. I also noted embodied actions that were of potential interest. This initial orthographic transcription facilitated familiarisation with the data through repeated viewing and listening. While undertaking this initial familiarising and transcribing, I remained aware of the definition of compassion developed for this study, listening and observing for expressions of suffering by the patient, ACP responses to this suffering, and patient receipt of these responses. As discussed in the methodology, this initial familiarising was not the entirely "unmotivated looking" (Sacks, 1984) some conversation analysts recommend. However, in the sense that I did not automatically categorise certain interactional features as compassionate, the research did adhere to the inductive principles of conversation analysis.

Following this initial phase of familiarisation, I identified single cases, which related to the research question and definition of compassion developed for the study, and undertook further detailed analysis. With the support of the software package Audacity[19], this stage of analysis involved the transcription of features such as silences, overlapping speech, pace, emphasis, prosody, and volume using the conventions for conversation analytic transcription (Jefferson, 2004) (see Appendix 8). Embodied actions were also noted if they appeared consequential to the analysis. This detailed transcription allowed me to capture not only what was said but how it was said (ten Have, 2007). I then used the recordings and transcript to analyse features of the talk including the organisation of turns, sequences, repair and turn design. Through this process of analysis, I built an empirical account of the interaction occurring in these single data extracts (ten Have, 2007).

The next stage of analysis involved building collections of cases, based on areas of analytic interest identified during single case analysis (ten Have, 2007). These collections need to be found frequently enough to build a collection (Sidnell, 2013) and be relevant to the research question (ten Have, 2007). Through the analysis of interaction in single cases I had, for example, started to identify areas of interaction where patients gave extended accounts regarding some problem, trouble or complaint. I therefore built a collection of patient accounts, and explored the different ways that these sequences unfolded. The building of this collection involved viewing all the data and transcripts, and identifying and time coding where patient accounts occurred. Analysis then involved shifting between the detailed transcription and analysis of single cases in the collection, and comparison with other cases. Through this process of single-case analysis and constant comparison, the analyst can look for systematic patterns in the data that are consequential to participants, in order to elaborate on the description of the interactional practice and develop an analytic account (ten Have, 2007; Sidnell, 2013; Clayman and Gill, 2004).

[19] Audacity is an audio editing programme which allows features of talk such as the length of silences to be measured.

During analysis of the collection, I analysed not only similarities within the data but also variations. In the present analysis, for example, I explored cases where ACPs orientate to patient accounts and cases where the ACP avoids explicitly orientating to patient's accounts of problems, troubles or complaints. Analysis of variations or deviant cases can show that participants are orientating to the same considerations as in the developing account, they can assist in revising the developing account, or the analyst may identify a different phenomenon (Clayman and Gill, 2004; Perakyla, 2004). Comparison was also made with what is already known about the actions and practices under investigation in both the applied and ordinary conversation analytic literature.

Throughout data analysis, initial interpretations were tested through viewing data and conversations both with supervisors and at group data sessions. Data sessions involve repeated viewing of a recording, in conjunction with a transcript, by a group of conversation analysts, who then share their observations. The purpose of these sessions include enhancing the accuracy of transcripts, encouraging deeper analysis of participants' practices, and testing and refining analysis (ten Have, 2007). As discussed in the methodology, conversation analysis is founded on the idea that analysis is based on the orientations and understandings participants' display within the interaction, rather than the researcher's interpretation of what they think is happening. Data analysis sessions assisted in confirming that findings exhibited transparency (Perakyla, 2004), and were therefore a means of enhancing the research's credibility.

4.11 Reflexivity

As discussed in the methodology, in comparison to other qualitative methodologies, conversation analysis focuses on the orientations and understandings of participants that are displayed within the interaction, rather than the understanding of a past event from a participant's perspective. As such, the transparency of claims regarding participants' orientations and understandings can be seen through the presentation of data, usually in the form of transcripts. Perhaps because of this transparency, and founding work focusing on unmotivated looking, reflexivity is not always explicitly addressed in conversation analytic studies. However, as with other qualitative methodologies

there is a need to engage in reflexivity. That is, "thoughtful, conscious self-awareness" (Finlay, 2002, p.531) regarding how the researcher's findings are embedded in the context of their production. Members come to data, with certain assumptions and ideas, and as a nurse, socialised into the profession, I had to be aware of both my status as a nurse, and my pre-existing assumptions about compassion in nursing practice. These assumptions about compassion included that compassion is a distinctive feature of nursing practice, which is exhibited through empathy, 'being there' and 'doing the small things'. Both my role as a nurse and my underlying assumptions regarding the role of compassion in nursing practice, therefore need to be considered in relation to the methods and analysis.

One purpose of presence in the research setting prior to collecting audio-visual recordings is to establish relationships and build trust (Caldwell and Atwal, 2005). Reflective notes suggest that ACPs may initially have had concerns that I was assessing their practice. During early shadowing, one ACP raised the issue of a patient who was shouting on the ward. The ACP accounted for the shouting stating that staff were not hurting the patient, but that she became distressed when moved. The ACP also described how staff tried to avoid distressing the patient but, when this was not possible, they moved the patient as quickly possible. While I had initially introduced the project, stating that I was interested in exploring compassion, this may have resulted in ACPs defending healthcare practice during early periods of shadowing. As discussed in the literature review, values-based healthcare focuses on the individual (Chaney, 2020; Pedersen and Roelsgaard Obling, 2019; Smajdor, 2013), and performance in healthcare is often measured at the individual level (Traynor, 2017). ACPs could therefore have perceived a proposal to research compassion, using audio-visual recordings, as potentially threatening. However, during conversations, such as that described above, I used previous nursing knowledge to display an understanding of the complex contradictory demands, which can be involved in nursing work. Using my insider knowledge of these dilemmas assisted in building rapport and trust in the researcher and a project that practitioners may have been cautious about. Reflecting on such events also allowed me to consider additional information ACPs may need about the study, for example, reiterating that the purpose of the research was not to evaluate individual practice. Having built relationships with ACPs during preparatory work I also had to be aware that this could make declining participation harder.

Throughout, I made it clear that ACPs did not have to participate, and with participating ACPs, I also respected days when it appeared particularly busy and ACPs declined to participate.

All participants were informed that I was a nurse, and I often spoke to patients on the ward prior to recording commencing. While likely that these practices increased the acceptability of the study, there is uncertainty about what impact they had on the consultation with the ACP. Some of the topics which patients discussed with the researcher, for example, lack of sleep and boredom, also became topics of discussion during the subsequent ACP-patient interaction. During one conversation, for example, the patient had discussed how a radio that a family had provided needed tuning. Despite offering to tune the radio, and potentially resolving the issue, the patient raised the same concern with the ACP. This example perhaps suggests that the patient would have raised the topic anyhow. As such, there is a lack of clarity regarding the influence conversations between the researcher and patient had on topics subsequently discussed during ACP-patient interaction, and the trajectory of these consultations. However, as conversation analysis prioritises the structure of talk and not the content, the impact of the researcher's talk with the patient before the consultation is likely to be minimal.

In relation to analysis, my socialisation as a nurse was both a help and a hindrance. As a nurse, I had an understanding of healthcare tasks, which assisted with analysis. For example, in one audio-recording where a cannulation was occurring, I was able to identify sounds of equipment being prepared for cannulation during a long silence. This example displays what Garfinkel and Wieder (1992) describe as unique adequacy. That is, the researcher must know what members (ACPs) would usually know about the setting (Rooke and Rooke, 2015). However, being socialised as a nurse, and therefore having been exposed and acculturated to views that 'being there', 'the small things' and empathy are important elements of compassionate nursing, I was initially reluctant to focus on data which appeared to contradict my assumptions regarding compassion. I did not want the research to result in either the profession or participants being criticised for not 'being compassionate'. There is a potential that as a member or insider such assumptions may hinder analysis. Wakefield (2000) describes how her professional values, including

dignity for the patient, hindered ethnomethodological analysis, when she observed poor patient care in a study exploring surgical nursing work. However, being able to recognise and reflect on these assumptions allowed me to adopt the ethnomethodological indifference necessary to focus on participants' orientations (see methodology section 3.1.2). As Rooke and Rooke (2015) state, in order to focus on participants' practices, in addition to bracketing theoretical knowledge, the researcher also has to bracket their beliefs. Once I had bracketed my knowledge and assumptions about compassion, I could focus on what ACPs were actually doing in their interaction. At this point in my analysis, I was able to use my insider knowledge, or unique adequacy, to explore what was actually happening within interactions. Rather than focusing on assumptions about the value of compassion, I was able to explore what ACPs and patients were actually orienting to in consultations. As a result, the next three analysis chapters focus on participants' orientations rather than the analysts. In chapter five, I explore ACP responses to patient's accounts of problems and troubles; chapter six explores ACP responses to patient complaints, and in chapter seven, I explore ACP responses to patient talk where there is trouble hearing or understanding the patient's talk (or ACP other-initiated repair). In all chapters, I focus on patients' subsequent responses, considering how their receipt of various ACP talk relates to the enactment of compassion.

Chapter 5 Analysis: Patient problem-talk and ACP responses

5.1 Introduction

In concluding the literature review, I proposed a working definition of compassion which included:

"A nurse's acknowledgement of the patient's suffering and the observable actions that the nurse undertakes (in an attempt) to reduce or alleviate suffering."

As patients' problem-talk is one area where patients may express suffering, identifying problem-talk, and ACP responses to this talk, seemed a straightforward place to start investigating possible compassionate practices by ACPs. Patients talked about a variety of problems, and ACPs responded in a variety of ways. In this chapter, I will provide a brief overview of the types of problems that patients talked about, prior to presenting some of the different ways in which ACPs responded to these problems - including affiliating with the problem, experience or patient's feelings regarding the problem. I will suggest that ACP responses depend on the context. In some contexts the ACP offers a problem-solution, which also affiliates with the patient's beliefs, and in other contexts, where there may be no clinical solution, the ACP affiliates with the patient's feelings or experiences. I will also present an instance where the ACP does not offer an explicit problem-solution or affiliation. I will consider why this response might occur and how it relates to compassion. Prior to presenting these findings, I will provide a brief summary of previous conversation analytic work on alignment and affiliation, and troubles-talk, in order to contextualise the findings.

5.2 Background

5.2.1 Tellings

As discussed in the methodology (section 3.2.1), an organising feature of interaction is the turn-taking system (Sacks, Schegloff and Jefferson, 1974). Within the turn-taking system speakers are guaranteed at least one turn-constructional unit of talk. In many instances, speakership changes at the end

of a turn, for example, in adjacency pairs such as a question-answer sequence. Following a question another participant should usually answer (Freed and Ehrlich, 2010). However, as Sacks et al (1974) show while speaker change can occur at a transition relevance place, speaker change is not automatic and depends on the context i.e. what is occurring within the interaction. Story-telling (or telling) is one activity which can occur over a number of turns. In fact, one of the characteristics of a telling is an extended sequence of talk by a participant (Mandelbaum, 2012). Tellings are therefore interactive productions, which are co-constructed by teller and recipient (Mandelbaum, 2012). That is, a teller has to show that they are commencing and later continuing a telling, and the recipient has to align with the telling. By alignment I am referring to the recipient's ability to recognise that a telling is in progress, and to support continuation of the telling to completion (Stivers, 2008). Through the use of acknowledgement tokens/continuers such as 'mm' and 'yeah', recipients align with a telling supporting its continuation (Jefferson, 1978; Lindstrom and Sorjonen, 2013; Stivers, 2008).

Structurally then, a telling involves one participant as teller and one aligning as recipient. A telling is not however, a neutral description of an event. Through the telling a speaker will describe their perspective or 'stance' regarding an event, indicating to the recipient whether the event is designed to be received positively or negatively (Jefferson, 1978). Rather than solely conveying information, tellings function as a means of sharing and achieving social solidarity (Lindstrom and Sorjonen, 2013). In addition to recipient alignment, if tellings are to facilitate this social solidarity, recipient affiliation is also necessary. By affiliation I mean the recipient conveying that they support and endorse the teller's stance (Stivers, 2008). Depending on the context, affiliation combines a variety of lexical, prosodic and non-verbal practices (Lindstrom and Sorjonen, 2013). Examples include assessments at telling completion, such as "that's fantastic" or "that's terrible'', and head nods during a telling (but not on completion) (Stivers, 2008). While affiliation is an interactionally preferred action (Lindstrom and Sorjonen, 2013), affiliation during tellings is a delicate issue, especially if the recipient of the telling does not have direct access to the event. That is where the recipient is required to affiliate with the experiences reported, but lacks the experiences and epistemic rights from which a compatible stance can be constructed (Heritage, 2011). In such cases a recipient may use non-specific responses such as "oh no" or "oh wow". For such

responses to be recognised as affiliative, Heritage (2011) does however, suggest that the response needs to be followed up with a more explicit affiliative response.

Arguably there are similarities between affiliation and compassion. Displaying and endorsing a teller's stance is similar to acknowledging an awareness of suffering. Ruusuvuori (2005b; 2007) uses affiliation and compassion interchangeably, in conversation analytic work exploring problem-presentation in GP encounters. However, there is no apparent detailed consideration about whether the terms can be used interchangeably. Given the definition of compassion developed for the current work, while acknowledging that affiliation may be a feature of compassion, the work does not commence from the stance that the two are interchangeable.

5.2.2 Troubles-telling

Tellings can perform a number of different actions. These include recounting a trouble or misfortune, complaining, blaming, accounting and justifying (Mandelbaum, 2012). Work focusing on troubles in everyday talk, or how participants describe the large and small events which afflict their lives, is part of the early foundational work in conversation analysis (Drew *et al.*, 2015). This work is directly relevant to the present chapter as patient problems are also describing the small and large events which afflict or affect the patient's life[20]. The recognition of a troubles-telling is however, dependent on more than just the content of the talk. Jefferson and Lee (1981) show how the organisation of talk provides for the trouble-telling. Jefferson (1988) proposes that there is a sequence to trouble talk, which moves from business as usual towards interactional intimacy as the trouble is developed, and then back towards business as usual. The structure outlined by Jefferson (1988) includes the approach to trouble-telling, arrival at the trouble telling, delivery which includes

[20] Problem-talk (or problem-tellings) and troubles-tellings can overlap, and they are used interchangeably in conversation analysis. Jefferson and Lee (1981) do however, draw a distinction suggesting problems-talk are part of sequences which result in a problem-solution or what they call a 'service encounter'.

the details of the trouble and affiliation, work up, closure implicative talk and exit from the trouble talk.

The troubles-telling sequence is not however, prescriptive. Jefferson (1988) found that many of the troubles-tellings analysed did not follow the exact sequence outlined. As a result of this finding, she concluded that the sequence is "vaguely orderly" (p.418). That is, the ordering of the sequence can be influenced by systemic local and general contingencies, such as interactional asynchrony and activity contamination (Jefferson and Lee, 1981). Interactional asynchrony occurs when the troubles-recipient does not align with a troubles telling, while activity contamination occurs when another activity converges with the trouble-telling, resulting in a different sequence. An example of the latter would be a recipient receiving troubles-talk as mitigation, and an excuse sequence occurring. Although not specifically referring to the healthcare setting, one particular form of activity contamination, which Jefferson and Lee (1981) discuss is that of a troubles-telling and service encounter. They distinguish between a troubles-telling, where the sequence focuses on the experiences of the teller, and a service-encounter, where the recipient is expected to offer a solution or service. Essentially, shifting from a troubles-telling to a service encounter means that roles are reversed – the troubles-teller becomes the recipient. While Jefferson and Lee (1981) do not dismiss the importance of service encounters, claiming that in some instances the service may relieve the problem, they show how the convergence of a troubles-telling and a service-encounter can create difficulties. Using data from a radio advice show, they outline how combining a troubles-telling and service encounter can result in inappropriate affiliation and rejection of advice. Although different contingencies will be at play in a healthcare setting, definitions of compassion used in healthcare combine understanding of the patient's suffering and the alleviation of that suffering (see Table 2.5, p.49). Essentially definitions of compassion combine the functions of both the troubles-telling and service-encounter, which Jefferson and Lee (1981) show is difficult to combine.

5.2.3 Problem-tellings in healthcare encounters

While in everyday talk a troubles-telling will often be undertaken as a means of facilitating social solidarity and cohesion, in healthcare the primary purpose of the consultation may be to resolve or provide a solution for a problem

(Ruusuvuori, 2005b). In relation to GP visits for new medical problems there is an organised interactional structure, including problem-presentation, history-taking and/or physical examination, diagnosis and treatment recommendation, and participants orient to this structure in order to obtain diagnosis, treatment and ultimately resolution of the problem (Robinson, 2003). Patients predominantly present their troubles, or what from here will be referred to as problems-talk or -tellings, in the problem-presentation phase of the consultation, with the GP leading other stages of the consultation (Robinson and Heritage, 2005). Building on this work Ruusuvuori (2005b) shows how, in relation to problems-tellings in GP visits and homeopathic consultations, patients and professionals orient to the institutional restrictions. In GP consultations, patient troubles were predominantly received with alignment, the continuation of an institutional task such as assessment, or other solution-focused talk such as a bright-side or optimistic telling. When a GP affiliated with a patient's problem-telling, the GP affiliated with the patient's experience and did not refer to their own experience (as may occur in everyday settings). Ruusuvuori (2005b) concludes that healthcare professionals have specific ways of showing affiliation, which navigate the potential difficulties of patient problem-tellings in an encounter that is essentially a problem-solving service encounter.

5.3 Problem-tellings in ACP-patient interaction

As the data were collected on hospital wards with patients who were, or had recently been acutely unwell, patient problem-talk was extensive throughout the data. In only one consultation was no problem-talk identified. This occurred in a consultation where a patient with dementia, who was to be discharged, responded almost exclusively with 'yes' and 'no' answers. In other consultations problem-talk occurred during different phases of the consultation (Robinson, 2003) including problem-presentation, history-taking, treatment recommendations, and as the ACP moved towards closing the consultation. This problem-talk also emerged through both patient presentation of problems and ACP elicitation of problems, and the topics of patient problem-talk varied widely. Patient problem-talk included, but was not restricted to, physiological concerns e.g. pain, nausea and breathing difficulties, the resultant problems undertaking activities of daily living, problems related to discharge, and problems related to the hospital environment.

While patient problem-talk did occur over only one turn, usually in response to an ACP question during the history-taking phase of the consultation, more extended problem-tellings were common. Problem-tellings extending beyond one turn occurred in all but three consultations. These extended problem-tellings also related to a variety of topics, and occurred during all phases of the consultation, although as would be expected, they were common during the problem presentation phase of the consultation. The actions performed by these problem-tellings also varied, and included accounting for conduct, recounting troubles, seeking a problem-solution, and complaining. Chapter 6 focuses specifically on compassion and patient complaints, while the present chapter focuses on ACP responses to patients' problem-tellings. I will begin the analysis with examination of an extract where the ACP responds to a patient's problem-telling with both affiliation and a problem-solution[21].

5.4 Demonstrating compassion in response to patient problem-telling

5.4.1 ACP affiliation with the patient's perspective and problem-solution

Extract 5.1 is from a consultation between ACP Rich[22] and Mrs Hayle, an eighty-eight year old, who had been in hospital for nine weeks. Originally admitted with a hip fracture, the patient had subsequently developed a number of other medical problems, spending time in high dependency. Discharge to a care home providing reablement had also occurred, but the patient was quickly readmitted to hospital. Fieldnotes describe how professionals had discussed the patient's

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[21] Research using conversation analysis to explore healthcare encounters, especially those in GP settings, has used the term treatment recommendations (Robinson, 2003) to describe the phase of the consultation where the clinician offers solutions. As outlined not all patients' problem-tellings were explicitly clinical, therefore the term problem-solution is used throughout.

[22] All names used are pseudonyms.

discharge to a reablement unit prior to the ACP-patient consultation. The extract occurs one minute thirty seconds into a ten-minute consultation. Prior to extract 5.1 the ACP and patient have talked generally about how the patient is feeling, and the ACP has summarised patient care provided. In line 1 the ACP introduces talk about discharge from hospital, which- given the patient history- could potentially be problematic.

Extract 5.1 "I couldn't go home"

(CiP09 v.3 L.72, Time: 01:28)

1	ACP	Uh:rm↓ (0.4) so from er:: a medical point of view and how
2		you <are (.) health wise> (0.7) you're probably good enough
3		to go home.
4		(0.8)
5	ACP	<Or at least not be in the hospital.>
6		(0.4)
7	Pat	Y:es, I agree with the second thing I couldn't go home:.=
8	ACP	=No
9		(0.4)
10	Pat	Because (0.8) >I couldn't lay there all night wait:ing<
11		£↑til somebody came >to go to [(the)£<
12	ACP	[No
13		((ACP looks down before 'no'))
14		(0.2)
15	Pat	I've got to be able to wa:lk.
16		(0.4) ((ACP head nod))
17	ACP	I'm glad that we're on the same page then.
18	Pat	<Yes.> ((Pat. head nod))
19		(0.3)
20	ACP	So what we've <asked: our> physio:therapy team to do is
21		referral to a: (0.2) a rehab facility:.
22		(0.2)
23	Pat	Ye:s ((Pat. head nod))
24		(.)
25	ACP	Get you walk:ing, get the strength back, get you feeling
26		safe enough to go home. ((Pat. nods during list))
27	Pat	Yeh. ((Pat. nods))
28		(0.2)

29 ACP Is that your understanding as well,=
30 Pat =Yes: ((Pat. head nod))
31 (0.2)
32 ACP Perfect:. ((ACP nods and looks away))
33 (1.5)
34 Pat I know once I can wa:lk (0.2) I can c cope with any (.) ev
35 everything else.

The ACP's talk (lines 1-3) introducing discharge from hospital suggests a potential delicacy regarding raising and discussing this topic. Prior to the ACP's assessment "you're probably good enough to go home" (lines 2-3), his talk includes hesitation and a justification "from a medical point of view and how you are health wise" (lines 1-2). A long silence follows (0.8 sec.), where the patient does not respond, suggesting that, from the patient's perspective, there may be issues with claiming a patient who cannot walk is "good enough" to go home. As Silverman and Perakyla (1990) show in HIV counselling sessions, silences can be used to confirm that the talk is interactionally delicate. The silence in line 4 confirms that the talk is delicate and avoids the patient having to explicitly contradict the ACP. Instead, the ACP expands, offering an alternative – "or at least not be in hospital" (line 5). The alternative confirms that the patient is ready for discharge, but also infers that she may not be returning home. The patient's response agrees - "yes, I agree with the second thing I couldn't go home." (line 7). While the ACP introduces the topic of patient discharge, and implies discharge may not be to the patient's home, the sequence provides space for the patient to explicitly state the problem that "they couldn't go home".

Following the ACP aligning as problem recipient in line 8 ("no"), the patient expands the problem, providing the justification for why she could not return home - "I couldn't lay there all night waiting £til somebody came to go to the£" (lines 10-11). In overlap with the conclusion of the patient's turn, the ACP responds with "no" (line 12). While the overlap may relieve the patient of having to fully articulate a sensitive topic, difficulty getting to the toilet overnight, the "no" also aligns with the patient's telling and affiliates with the patient's stance that she could not wait all night for help. The patient does not complete her turn, perhaps accepting that the ACP understands the upshot of her previous talk, and instead moves to what needs to occur for her to be able

to return home, "I've got to be able to walk" (line 15). In line 17, the ACP agrees with the patient's stance, offering an assessment of the talk – "I'm glad that we're on the same page then". Interestingly, the ACP's affiliative turn does not contain the explicit understanding of internal feelings and motivations, which Hepburn and Potter (2007) describe as empathy, or an assessment of the trouble, such as "how awful", which Jefferson (1988, p.428) describes as affiliative in everyday talk. The ACP's turn does not offer the explicit empathy (or sympathy), which previous research suggests is a component of compassion in healthcare practice (Bessen *et al.*, 2019; van der Cingel, 2011; Sinclair *et al.*, 2016a). Offering a response such as 'that would be terrible' or even 'you sound worried' may affiliate and acknowledge the unacceptability of 'laying there all night', but the response could potentially risk exposing the patient's limitations. As Parry (2004) shows, healthcare professionals actively avoid exposing patient limitations or incompetence, claiming this avoidance is a means of maintaining the patient's 'face'[23]. The ACP's meta-commentary – being "glad that we are on the same page" (line 17) therefore affiliates with the patient's talk, without dwelling on the patient's limitations. In line 18, the patient responds "yes" confirming that the patient and ACP share the same stance regarding the patient returning home.

In relation to the definition of compassion, in lines 1-18 the patient's suffering has been acknowledged and the ACP has affiliated with the patient's stance that resolution of the problem involves getting the patient walking. In lines 19-32 the ACP informs the patient how the problem will be resolved – referral to a rehabilitation facility (line 21) and the justification - "get you walking, get your strength back, get you feeling safe enough to go home." (lines 25-6). Again, the turn is sensitively constructed – there is no emphasis on who is responsible, the focus is on what can be achieved rather than the patient's limitations, and "feeling safe" is perhaps a more justifiable and acceptable reason than 'feeling you can cope'. The justifications listed by the ACP also explicitly affiliate with the patient's perspective regarding the problem. "Get you walking"

[23] 'Face' refers to the positive social value participants give and receive during social interaction (Goffman, 1955)

acknowledges the patient's problem "I've got to be able to walk" (line 15) and "get the strength back" potentially relates to earlier talk (not shown), where the patient had claimed problems getting out of bed were related to "weakness"[24]. The final part of the list - "get you feeling safe enough to go home" (line 26), demonstrates that the ACP has acknowledged the patient's perspective regarding returning home. Throughout the patient agrees with the ACP's interpretation of the problem and the patient's feelings. The patient commences nodding her head when the ACP commences "strength back" and the head nodding continues throughout "get you feeling safe enough" (line 26). Stivers (2008) shows how head nodding is one method for recipients affiliating with the speaker's stance. On conclusion of the ACP's list the patient immediately responds "yeh" (line 27) and, following the ACP's "perfect" (line 30) and a long pause, the patient states "I know once I can walk I can cope with any (.) ev everything else." (lines 34-35). While the patient's turn projects a future point where the problem will be resolved, it also reinforces a current inability to cope, which concurs with and reinforces the ACP's expressed understanding of the patient's view.

In extract 5.1, then, the ACP proposes a solution that the patient agrees with. While the ACP's offer of a solution which potentially alleviates suffering, appears to fit with the definition of compassion developed, how the solution is offered is also relevant to how compassion is enacted. The ACP affiliates with the patient's stance that she cannot return home, displays an understanding of the patient's concerns, and avoids explicitly voicing the patient's limitations, while presenting the problem-solution. Extract 5.1 is however, a scenario in which the ACP and patient can easily agree on the desired outcome, and the desired outcome is available for the ACP to offer. Not all patient problems-tellings in healthcare interactions are so straight-forward. ACP and patient may not always agree about a problem, there may not be a clinical solution or a way to reconcile a clinical solution with patient wants and feelings, and other institutional and interactional demands may be prioritised.

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[24] Following the ACP asking "how do you feel" at the start of the consultation, the patient replies that they are a lot better until they get out of bed. The patient reports that they go dizzy, claiming "it's weakness"

5.4.2 ACP affiliation with the patient's feelings and experience.

While extract 5.1 contained evidence of affiliation with the patient's problem and a problem-solution, extract 5.2 contains interaction where there may be no clinical solution. Extract 5.2 occurs seven minutes forty-eight seconds into a thirteen-minute consultation between ACP Rich and Mrs Reeve, a ninety-one year old, admitted from a care home with cellulitis, six days before the recorded consultation. Six minutes forty-nine seconds into the consultation, the ACP had commenced a respiratory assessment, asking a general question about how the patient's breathing feels. The patient had responded "I'm alright when left alone". A patient complaint had then followed, with the patient complaining about nursing staff ignoring her. In lines 1 and 2 of extract 5.2, the ACP returns to the clinical agenda with the claim that he is thinking "about the best things to do for you", which potentially acknowledges the lack of a problem-solution. The ACP then reintroduces the patient's shortness of breath.

Extract 5.2 "Any exertion you know"

(CiP14 v.2 L244) Time: 09:52

1	ACP	°Okay° tsk I'm trying to think of th about the best things
2		to do for you. (0.5) You <↑sound> a bit short of breath at
3		the minute.
4		(0.4)
5	Pat	Yeah
6		(1.3)
7	ACP	↑That's new isn't it.
8		(0.7)
9	Pat	Well (0.7) no (0.6) not when: (0.3) not when I'm talking.
10		(.)
11	ACP	O:kay
12		(0.5)
13	Pat	No (0.9) (an hhit) (0.4) any exertion [you know,
14	ACP	[(mm)((ACP nods
15		head))
16		(0.6)

17 Pat hh the (worse) (3.0) (part) about me being (1.6) short of
18 breath (0.3) >it's when I'm at home >not when I'm here.<
19 (.)
20 ACP Yeah.
21 (0.2)
22 ( ) Tsk
23 (0.6)
24 Pat An: (0.6) I go an have a shower. >The carers take me for a
25 shower.< (0.7) Get ba:ck (.) ↑help me to get dress:ed:.
26 (0.8) Well I: just sit there. (1.0) You know,
27 (0.2)
28 ACP Knackered
29 (0.2)
30 Pat Yeh, (0.6) yeah. Til (0.7) til I've got my breath back
31 th:en: (0.8) I sit down.
32 (1.2)
33 ACP tk we:ll what I'm go:ing to do (0.2) so I'm going to come
34 and take a few more blood tests off of you (0.4) >so you'll
35 get a bit more company for a bit even if it's just me<
36 stabbing you in the a:rm:. (0.8) Uh:rm (0.7) I'm going to
37 ask them to come and do that <examin:ation> that I asked
38 them to do.

In comparison to the question "how does your breathing feel", which the ACP asked earlier, "you sound a bit short of breath at the minute" (line 2-3) raises a possible problem. While suggesting a potential problem, the ACP's request for information does defer to the patient's epistemic rights over her symptoms and feelings (Heritage, 2010; Raymond and Heritage, 2006). The potential problem is downgraded with "a bit" and the use of "you sound" defers to the patient's actual experiential knowledge of her symptoms. The patient agrees and, following a silence, the ACP states "that's new isn't it." (line 7). The ACP's assessment of the shortness of breath being new is based on the ACP's previous knowledge, but again he defers to the patient's epistemic rights over her symptoms, seeking confirmation from the patient with the tag question "isn't it". The ACP is identifying a potentially new problem that may require investigation and treatment. However, the patient's answer disconfirms the ACP's suggestion that the shortness of breath is a new problem ("well no not when not when I'm talking", line 9). The ACP responds with "okay" and the patient expands her

answer with "any exertion you know" (line 13). In overlap the ACP aligns with "mm" and affiliates with a mid-telling head nod (line 14) (Stivers, 2008). The patient continues, setting the scene for an extended problem telling, stating that she is going to talk about the worst part of being short of breath when she is at home (lines 17-8). The ACP responds to the patient's lead-up to the troubles-talk (Jefferson, 1988) with an aligning "yeah", and the patient continues her telling describing how carers take her for a shower and help her get dressed (lines 24-5). The patient concludes the telling with the upshot formulation, "well I just sit there" (line 26), which in relation to showering and dressing could be described as an extreme case formulation. A silence follows and the patient adds "you know" (line 26), emphasising that the telling is complete and seeking a response from the ACP (Sacks, Schegloff and Jefferson, 1974). The ACP responds with "knackered" (line 28), an informal word, which suggests an understanding of the level of exhaustion the patient experiences following showering and dressing.

Whereas in extract 5.1, the ACP affiliated with the patient's beliefs regarding the practical problem of returning home, in extract 2.5 use of the word "knackered" (line 28) appears to both affiliate with the patient's stance on showering, and display an understanding of the physical and/or psychological consequences of the task. The ACP's turn clearly names the patient's feelings and could be described as an empathic receipt (Hepburn and Potter, 2007). The patient responds with a repeated "yeh, (0.6) yeah" (line 30). Muller (1996) uses the example "oui oui oui" to show how multiple sayings by a recipient can be used as a strong recognitional (p.135) or method to upgrade a simple agreement. While there is a pause between the patient's multiple acknowledgements in line 30, and they are pronounced differently, the second "yeah" in particular is hearable as an upgraded agreement, suggesting that the ACP has understood her problem. Additionally, the patient does not elaborate further on her difficulties, suggesting she is satisfied that the ACP has understood. Instead, the patient moves away from the problem towards how she resolves it – sitting there "til I've got my breath back then I sit down" (lines 30-1). By recounting how she has resolved the problem, the patient suggests that there is nothing new for the ACP to do, and in lines 33-38 the ACP moves to a treatment/investigation plan, for a problem unrelated to the immediately prior talk. The "well" in line 33 indicates that this is a topic shift (Heritage, 2015), and access to the whole consultation confirms that the blood tests and

examination the ACP proposes relate to bleeding, which the patient has disclosed earlier in the consultation. While the patient does present a problem in extract 5.2, it is not the new problem suggested by the ACP and the patient does not indicate that a solution is required. In extract 5.2, where the problem is unlikely to be resolved, the ACP's use of "knackered" (line 28) offers a turn, which not only affiliates with the patient's difficulties regarding showering, but also displays an understanding of the patient's feelings. While not resolving the suffering associated with the macro-problem, the turn could be considered compassionate within the micro-context of talk.

5.4.3 ACP affiliation and problem solution followed by patient rejection of the problem solution

In the first two extracts I have shown how ACPs respond to patient problem-tellings in ways which could be described as compassionate. In extract 5.1 the ACP affiliated with the patient's problem and offered a solution, while in extract 5.2 the ACP did not offer a solution. Instead, the ACP affiliated with the patient's difficulties with showering and displayed understanding regarding the consequences. Extract 5.3 presents another example of how compassion may be displayed by ACPs during a patient problem-telling. The context and outcome are however different. As with extract 5.2, the problem in extract 5.3-boredom - is perhaps more of a general than explicitly medical problem. However, in extract 5.3 a solution is offered and rejected by the patient. Extract 5.3 also starts to demonstrate some of the complexities of ACP affiliation with patient problems, as the analysis will show. The extract is from a ten-minute consultation between ACP Eve and Doreen, a ninety-one year old, who was admitted to hospital following a blackout. The patient had subsequently been diagnosed with heart failure, and had been in hospital for sixteen days when the consultation occurred. Eve had not previously cared for Doreen and the purpose of the consultation was to conduct a daily clinical review. This review usually included assessment of ongoing medical conditions and their impact on daily living, medication review, discussions about discharge, and examination where indicated. The extract occurs fifty seconds into the consultation. The ACP has asked the patient how long she has been in hospital, the reason for admission and summarised the reasons for the patient's admission. Following this summary, the ACP proceeds to focus on the present asking, "how are you

feeling today" (line 1). The patient's problems regarding being tired, having nothing to do and difficulty using a radio all originate from this question.

Extract 5.3a "I don't have anything to do"

(Transcript CiP 22 v.3 L29) Time: 00:50

```
 1  ACP     ↑How are you <feel:ing ↑today: now.
 2          (0.3)
 3  Pat     .hh Well I'm (0.2) very tired today.
 4  ACP     <Are you:>
 5          (0.2)
 6  Pat     But and this (0.7) >I don't have anything to do< because
 7          .hhhh I've been registered as partially sighted.=
 8  ACP     =M:m.
 9  Pat     So I can't rea:d.
10          (0.4)
11  ACP     M:h[m:
12  Pat        [£I can't watch tel[evision (but/cos)) there isn't any£)
13  ACP                           [>So you're getting a bit<
14          £↑bor(ed/ing)£
15          (0.4)
16  ACP     You're ↑getting a bit <↑bor:ed:>
17          (0.3)
18  Pat     Just a lit[tle.
19  ACP               [◦I know:.◦
20          (0.3)
```

In response to the ACP's question regarding how the patient is feeling (line 1), the patient announces the problem with "well I'm very tired today" (line 3). The ACP aligns as a recipient of the problem responding with "are you" (line 4), and the patient expands her problem-telling explaining "I don't have anything to do" (line 6) and the reason for this - "because I've been registered partially sighted." (line 7). The ACP responds with the continuer "mm" (line 8), aligning as the recipient of a problem-telling, and the patient continues expanding the problem, stating that she cannot read (line 9) or watch television (line 12). As the patient completes the word television, which could be projectable as a turn completion, the ACP responds formulating the outcome of what the patient has

been saying (line 13). While the ACP's turn is repeated, either self-repairing 'boring', or because the turn is said in overlap, the ACP's formulation "you're getting a bit bored" (line 16) potentially affiliates with the feelings that result from 'having nothing to do'. The patient responds "just a little" (line 18), which appears to confirm the ACP's assessment summary, and following an affiliative "I know" (line 19) both the ACP and patient appear to move away from the problem-telling stage of the sequence to problem-solution.

While the affiliation exhibited in "you're getting a bit bored" (line 16) acknowledges the patient's suffering, both the ACP's turn and the patient's subsequent confirmation ("just a little", line 18) suggest that acknowledging suffering is challenging and requires a certain delicacy. As recognised in conversation analysis, there are challenges around who has the right to know what – only the patient has direct access to their feelings and experiences (Peräkylä, 2002). That is, a patient has epistemic rights over their feelings. The tentative, downgraded construction of the ACP's turn, including the use of "getting" rather than 'is bored' and "a little", may show that she is alert to issues regarding epistemic primacy. 'Face' considerations may also be being oriented to in the affiliative turn and response. In analysing extract 5.1, I suggested that the construction of the ACP's affiliative turn, which avoided an explicit assessment of the patient's problems, potentially avoided exposing the patient's limitations. By focusing on feelings associated with the problem, the ACP again avoids exposing the patient's limitations of vision. The patient's response "just a little" (line 18) also potentially allows the patient to agree, without displaying herself as someone who complains or 'makes a fuss'. While the patient's next turn is unclear (line 22), the turn appears to be starting to explain what the patient and her family have done to mitigate 'boredom'[25]. This turn appears to support the claim that the patient is orientating to displaying herself as someone who does not like to make a fuss, and despite limitations is still able to help herself and solve problems. In delivering an acknowledgement of suffering, ACPs are therefore potentially navigating a number of competing demands – acknowledging and showing understanding that the patient is

[25] Fieldnotes and later talk suggest the patient's talk in line 22 may have been commencing talking about strategies family had tried to provide something to do – buying a radio. The patient takes up talk about the radio at line 55.

suffering, while recognising the experience is the patient's and, of particular relevance in health care of the older person, avoiding exposing limitations.

Extract 5.3 continues as follows:

Extract 5.3b "I don't have anything to do" (continued)

(Transcript CiP 22 v.3 L29) Time: 00:50

21	ACP	[↑What ↑about audio] (0.2) ◦audio book[s::?
22	Pat	[So (?name?)] [(sons:)
23		(0.6)
24	ACP	◦◦<No?>◦◦
25		(0.3)
26	Pat	I can't (0.6) hhh <er> (0.6) >I have(n't) got< audio books
27	ACP	M:m.
28	Pat	But they go through my <i:pad.>
29		(0.4)
30	ACP	°O:kay°
31		(.)
32	Pat	<And> (1.0) when I have to switch it on (0.3) .hh <pause>
33		(0.4) if someone comes:. (1.0) I can't get it £↑back
34		again.£= ((laugh.h[hh £and the/there's a)
35	ACP	[Can you not £cos you canna hhh£)
36		(.)
37	Pat	↑Well ↑it's: (.) it's not on number (two [it's on)]
38		
39	ACP	[(<◦Yeah◦>]
40		(0.2)
41	Pat	those silly mo:jo
42		(0.5)
43	ACP	◦Mm:◦
44	Pat	(Drive me) to <despair.>
45		(.)
46	ACP	◦O:kay.◦
47	Pat	So I've lost my story.
48		(0.4)
49	ACP	↑Have yur

50 Pat So: [that] ↑didn't work very well
51 ACP [( )]
52 (0.2)
53 ACP ◦Oh dear.
54 (.)
55 Pat So now we've bought this (0.4) little radio.
56 (.)
57 ACP Fabulou[s.

As in extract 5.1, following ACP affiliation and agreement from the patient, the ACP proposes a problem-solution – "what about audio (0.2) audio books" (line 21). However, in extract 5.3b the patient rejects the ACP's problem-solution. While offering a possible solution to the problem, the question format allows for the fact that the patient may already have tried audiobooks. However, the proposal puts the patient in the position of having to reject the suggestion, and a silence follows. Subsequently, the ACP acknowledges that there may be a problem with the proposed solution of audio books, answering her own question with "No?" (line 24). By acknowledging that the patient is rejecting the proposal, the ACP assists in providing a space where the patient can elaborate. The ACP's "no?" also makes an explanation necessary and in lines 26 to 47 the patient commences another problem-telling, which explains why audio-books are not suitable and mitigates her rejection. The patient commences with "I can't" (line 26) suggesting something problematic, before abandoning the turn and re-commencing with preliminary information about not having audiobooks (line 26), but obtaining books through her "i-pad" (line 28). The ACP aligns as a problem-telling recipient and the patient goes on to explain the problem – if she has to pause a story she can't get it back on (lines 32-4). While in line 35 the ACP may have been commencing a formulation of the patient's talk with "can you not cos you canna", the ACP abandons completion of the turn. Again, 'face' considerations may be evident in the ACP's abandonment of the turn. While "you canna" could be displaying understanding, it may also be implying patient inability as a component of the problem. Certainly, in line 37 when the patient continues her problem-telling she commences with "well" suggesting an alternative (Heritage, 2015) and then attributes the problem to the i-pad "it's

not on number two it's on (0.2) those silly mojo"[26] (lines 37-41). From lines 44 to 50 the patient continues her problem-telling explaining that it "(Drive me) to despair" (line 44), that she loses her story (line 47) and then indicating completion of the telling with "so that didn't work very well" (line 50). Throughout these turns the ACP aligns as recipient of a problem-telling, and only following the patient explicitly indicating completion of the telling does she respond with the affiliative "oh dear" (line 53).

In comparison to previous examples where the ACP affiliates with the patient's feelings or the consequences of the problem, the ACP's assessment "Oh dear" affiliates explicitly with the patient's stance regarding the use of audio books. This type of affiliative assessment is frequently described in research focusing on problem-tellings in everyday talk (Jefferson, 1988), and there may be good reasons for it occurring at this point in this interaction. Firstly, the problem is not explicitly clinical, but boredom related to difficulty using the i-pad. Secondly, the ACP has already tentatively proposed a solution, which the patient rejected. With an explicitly clinical problem, the ACP may be able to provide a clear problem solution, for example, analgesia may be offered to alleviate pain. However, in the context of healthcare of the older person, trying to solve problems that are not explicitly clinical, and where the solution is potentially subjective, risks rejection of the solution. Where problem solutions are rejected, affiliation with the patient's stance is potentially a means of acknowledging patient's efforts, supporting their conclusions, and building social cohesion.

5.5 Patient problem-tellings when ACP affiliation and problem solution are not evident

In extracts 5.1 to 5.3, I have presented data where ACPs use various practices to affiliate with the patient's problem-telling, regardless of whether the ACP offers a problem-solution which the patient agrees with or accepts. In extract

[26] "Mo-jo" = emoji

5.4, I will present data where affiliation and a clear problem-solution are not initially offered, and the patient pursues her problem-telling. Extract 5.4 is taken from a nine minute consultation between ACP Sarah and Cecilia, an eighty-five year old who had been admitted to hospital following a fall. Sarah and Cecilia had previously met and the patient was due to be discharged home on the day of the consultation[27]. The extract occurs at the start of the consultation and the problem concerns neuropathic pain and effective treatment.

Extract 5.4a "My legs were so painful"

(CiP02, v3 L7) Time 00:12

1	ACP	↑How are you? ((ACP enters/sits on bed at side of pat.))
2		(0.5) ((Pat puts glasses in case/puts on table))
3	Pat	I'm alright, bu:t urhm (.) in the night, I had (0.5) I must
4		have been sitting on a nerve.
5		(0.2)
6	ACP	<<A[rh:.>>] ((ACP closes mouth and lowers shoulders))
7	Pat	[because my] f:eet were frozen and my legs were so
8		painful these awful feelings were [(running) up and] down.
9	ACP	[Came back?]
10		(0.7)
11	Pat	But: uhm (0.4) <I managed> to turn over and (0.5) >did a
12		lot of wriggling with my feet [and I< and that and=
13	ACP	[Right
14	Pat	(he/it) got them (.) eventually [>and then they<]=
15	ACP	[Right]
16	Pat	=warmed up again.
17		(.)
18	ACP	O:kay.
19		(.)

[27] This extract is taken from the start of the first consultation recorded with Sarah (ACP). Afterwards, the ACP did state that she was conscious of being recorded at the start of the consultation. Given the nature of the project, it is not known what impact this may have had on the ACP's interaction.

20 Pat It was awful () >I don't (think) I must hav< must have been
21 on the (.) right on the nerve that's=
22 ACP =◦Okay◦=
23 Pat =caus:ing all the trouble. (0.4) It's got to be down here
24 at the base of this right hand side.
25 ((Pat. leans forward and points))
26 ACP <◦Righ[t.◦>
27 Pat [Because that was the si: (.) when I turned onto my
28 left thi (0.4) buttock it was alright, you know (cos I'd
29 put up with it.)
30 (0.3)
31 ACP <So there's> quite a lot of sc:ope to increase that (0.4)
32 tablet I [<star]ted.>
33 Pat [↑Is there?]

In extract 5.4, the patient's problem-telling commences following the ACP's generic opening question ("how are you", line 1). The patient responds with "I'm alright," (line 3) before announcing "but I must have been sitting on a nerve" (line 3-4). In line 6, the ACP responds with a slow "arh", with which she both aligns as recipient of a problem-telling and affiliates. While some have suggested that response cries show sympathy rather than empathy, because they do not articulate understanding of the other's emotions (Hepburn and Potter, 2007), others have claimed response cries show the recipient is involved in the feelings of the other (Heritage, 2011). Certainly, in the present extract the ACP appears to be acknowledging that "sitting on a nerve" was a problem for the patient. In overlap the patient continues, explicitly stating the problem, "because my feet were frozen and my legs were so painful these awful feelings were running up and down" (line 7-8). Towards the end of the patient's turn, in overlap, the ACP states "came back?" (line 9). "Came back?" serves a number of potential purposes including indicating a possible transition from patient problem-presentation to history-taking (Robinson, 2003), and displaying the ACP's understanding that the problem is a recurrent rather than a new problem.

Following the ACP's "came back" (line 9) and completion of the patient's problem-telling (line 8) a misalignment occurs. A 0.7-second (line 10) silence follows, during which the patient does not affirm that the pain 'came back' and the ACP does not offer a problem-solution. In relation to the organisation of GP

consultations, Robinson and Heritage (2005) show how GP and patient orient to the patient's completion of reporting current symptoms as the end of problem presentation, with the GP progressing the consultation to a subsequent stage - history-taking, diagnosis or treatment recommendation. The ACP does not however, affiliate or progress talk to problem-resolution at the possible completion of the patient's problem-presentation in line 8. Instead, an extended problem-telling by the patient (lines 11-29) follows, which includes negative assessments regarding the problem - "It was awful" (line 20), explanations and hypothesis - "I must hav must have been on the (.) right on the nerve that's causing all the trouble" (lines 20-4), and self-care - "did a lot of wriggling with my feet" (lines 11-12). The ACP aligns as the recipient of the patient's extended problem-telling, responding with continuers such as "right" (lines 13, 15 & 26) and "okay" (lines 18, 22). It is not until the patient selects the ACP as next speaker, explicitly displaying that the problem-telling is complete ("you know (cos I'd put up with it)", line 28-29), that talk progresses from problem-telling to a problem-solution, with the ACP stating "there's quite a lot of scope to increase that tablet I started" (lines 31-32). There is however, evidence of possible interactional difficulties in the patient's problem-telling in lines 11 to 28. In addition to hesitation and self-repair, the problem-telling includes talk about what the patient did to resolve the problem (lines 11-12 and lines 27-28). Patients have been shown to talk about self-care to justify problem-presentation (Heritage and Robinson, 2006). There are two possible inter-related explanations for the patient's difficulties. Firstly, while the ACP has aligned as the recipient of a problem-telling, following the "arh" in line 6 further affiliation is absent. When Heritage (2011) claims that response cries such as "arh" are empathic, he also claims that the response cry acts as an "emotional I owe you", which will require subsequent explicit affiliation (p.173). The patient's ongoing problem-telling may therefore be due to the absence of explicit ACP affiliation with her stance. Secondly, the patient may be orienting to completion of the problem-telling and the institutional norm that history-taking and/or a treatment recommendation will follow. While previous research may suggest listening and giving patients time to express a problem is important (Figure 2.2, p.36), the timing of affiliation and problem-solution in interaction are also important (Jefferson and Lee, 1981). Delaying affiliation and/or a problem-solution may result in the patient having to do more work to achieve a satisfactory problem-solution, as the continuation of extract 5.4 below shows.

Extract 5.4b My legs were so painful (continued)

(CiP02, V3 L7) Time 00:12

ACP <So there's> quite a lot of sc:ope to increase that (0.4) tablet I [<star]ted.>

Pat [↑Is there?]

(.)

ACP Yes, >you're only on a very low dose.< =We start a low dose and make sure there are no side effects. =And then we [gradually increase]

Pat [Well I haven't had any] <side effects> but= =[I wouldn't mind] a bit more if that's [gonna to help]=

ACP [Perfect] [Yes:.

Pat =beca[use it was a horri]ble> feeling in my= =feet, it (0.3) they (.) the don't <feel> as if they belong to me >when I go like [that< it's]=

ACP [I think >that would be the one.<]

ACP [<Yea:h>]

Pat =like, ((Pat rubbing hands together))

(0.5)

ACP Strange, >↑isn't it,<

(0.3)

Pat Uh it's <weird.> =Yes:

ACP Definitely sounds like a <nerve>

(0.4)

Pat It [I think it] i:s.=

ACP [[(kind of thing)]

ACP =So I think that tablet's the <right one.>

(0.4)

Pat Good

ACP Uh:rm but we definitely >can have a lot of scope< to increase that So we'll (.) we'll increase it <↑here,>

Pat <Yes:.>

ACP Uhrm [and then we'll ask the GP]

Pat [(Well) I'm going home]

While the problem-telling sequence concludes when the ACP commences a possible treatment recommendation, the continuation of extract 5.4b shows that there are difficulties with this turn, and the patient resumes talk about her pain

(lines 41-44). Initially, the patient responds to the ACP's informing that the medication can be increased as news, asking "is there" (line 33). The ACP confirms the information with "yes" before explaining why the dose can be increased ("you're only on a very low dose", line 35), and justifying the initial low dose, which was started to make sure that "there are no side effects" (line 36). In overlap with the ACP's justification, the patient claims "well I haven't had any side-effects" (line 38) and then issues a low entitlement request (Curl and Drew, 2008) - "I wouldn't mind a bit more if that's gonna help" (lines 39). The patient then resumes her problem-telling assessing the sensation in her feet as "horrible" (line 41), claiming "the don't feel as if they belong to me" (line 43-4) and concluding with "it's like" and the rubbing of her hands (line 46). In previous extracts discussed in this chapter the problem-telling concludes following affiliation, regardless of whether the problem is resolved (or in the case of extract 5.3a/b a new problem-telling commences). Resumption of the problem-telling in extract 5.4b suggests that from the patient's perspective alleviation of the problem may not have occurred. Again, there are a number of potentially inter-related explanations. Firstly, there is no explicit affiliation with the patient's stance prior to the implied problem-solution. Jefferson (1988) showed that the troubles-telling sequence was "vaguely orderly" (p.419) with local contingencies influencing the order. Lack of affiliation may be one issue, which could result in pursuit of the problem. A second related factor is that, the problem-solution offered by the ACP appears to display only limited understanding of the problem. The solution does not include understanding of the patient's experience or feelings (as opposed to what was seen in extract 5.1). Finally, "there's quite a lot of scope to increase that tablet" (line 31) does not include an explicit treatment recommendation, such as an offer or proposal (Stivers and Barnes, 2018), and the patient receives the ACP's informing with the news receipt "is there?" (line 33). Ultimately, in line 39 the patient proceeds to request the increase in medication. In everyday talk, a recipient offer is generally preferable to the speaker having to request (Schegloff, 2007), because with a request obligations are placed on the recipient. That is, with a request the recipient has to agree to do something. In healthcare encounters, participants orient to the offer or provision of a treatment recommendation by the healthcare professional (Robinson, 2003). Treatment recommendations are usually within the domain of the healthcare professional. Having requested an increase in medication the patient therefore has to justify the request. In extract 5.4b this justification involves a re-articulation of the problem presentation.

The lengthy initial problem-telling and the resumption of the problem-telling following the move into the treatment recommendation phase of the consultation in extract 5.4a/b, provide further evidence regarding what compassionate responses to a patient's problem-telling might entail. There is evidence to suggest that when explicit affiliation with the patient's feelings, experiences or stance is absent from a problem-solution, the patient may pursue the problem-telling in order to seek this affiliation. Ultimately, in extract 5.4b, when the patient states that "the don't feel as if they belong to me when I go like that, it's like" (line 43-4) and rubs her hands together, the ACP responds with a candidate assessment ("strange isn't it", line 48), which affiliates with the patient's out of the ordinary experience. The patient's assessment "it's weird" (line 50) agrees, suggesting that the ACP's assessment has been received as accurately affiliative. From here the treatment recommendation phase is entered with the ACP confirming that "it definitely sounds like a nerve" (line 51), that the medication is "the right one" (line 55) and finally an explicit statement about what she will do with the medication: "we'll increase it here" (line 59). The patient agrees to the increase in medication, and the problem-telling concludes suggesting that the patient's problem is adequately resolved. That the patient's problem-telling is not pursued, following the ACP's affiliative response and explicit problem-solution, suggests that within healthcare of the older person, a combination of explicit affiliation, and where appropriate a clear problem-solution, may be an accountable action.

5.6 Discussion

The chapter commenced by proposing that a possible place to explore the enactment of compassion within ACP-patient interaction was where patients display a problem. A patient's problem-telling is a potential location for the patient to display suffering and for ACPs to respond compassionately. There is an assumed relationship between the articulation of suffering and a compassionate response to suffering, proposed within the definition of compassion developed. In extract 5.1, I presented data showing how ACPs can affiliate with the patient's stance and offer a problem-solution, which is accepted by the patient. In extract 5.2, the ACP affiliated with the patient's experience and feelings, expressing empathy, but did not offer a problem-solution. There is no obvious clinical solution to be offered in this scenario and, following the ACP's

affiliation, the patient informs the ACP of how she resolves the problem herself. In extract 5.3, the ACP affiliated with the patient's experience and offered a solution; however, the patient rejected the solution on the basis she had already tried it and adopted an alternative. While these examples may not contain the upgraded assessment which are practices for showing a response has been received as affiliative in everyday talk (Jefferson, 1988), the patient's responses show that the ACP's actions are treated as adequate in each context, and the consultation progresses. Extract 5.1 to 5.3 therefore suggest that ACP affiliation with the patient's feelings, experiences or stance are received as sufficient to acknowledge suffering in this setting. Certainly, in extract 5.4a/b, when neither explicit affiliation nor a clear problem-solution follow the patient's problem-telling, the patient re-commences her problem-telling, suggesting that the ACP's initial response may not have been received as adequate. Later in extract 5.4b, when affiliation with the patient's stance and a problem-solution are offered, the patient agrees and accepts this, and the consultation progresses.

In relation to the definition of compassion used in this research, the investigation of ACP patient problem-tellings clearly shows a number of practices ACPs use to acknowledge patient suffering. However, whether the ACPs' responses display the "actions that the nurse undertakes (in an attempt) to reduce or alleviate suffering" is debateable. The outcomes of extracts 5.1 to 5.3, in terms of problem solution vary. In extract 5.2 a problem-solution is not offered and in extract 5.3 a problem solution is offered but rejected by the patient. From a clinical perspective the claim may be made that extract 5.2 and 5.3 do not evidence the alleviation of suffering, and are therefore not compassionate. There are however, situations in healthcare where the patient's problems may not be resolvable. These situations include healthcare of the older person where multi-morbidity, frailty and deteriorating health may all be co-present and where cure is not possible. Such situations have been widely acknowledged (Baker *et al.*, 2018; Gawande, 2014). Previous research exploring patients' and health care professionals' perceptions and experiences of compassion have recognised that there may not always be a clinical solution to a problem (Sinclair *et al.*, 2016a; van der Cingel, 2011; van der Cingel, 2014). As a result, some authors have concluded that the alleviation of suffering occurs through displays of understanding and/or an acknowledgment of suffering (Sinclair *et al.*, 2016a; van der Cingel, 2011). While extracts 5.1 to 5.3 show acknowledgement and/or understanding of the patient's suffering, proof that

these practices alleviate suffering is more circumspect and we can only use interactional evidence. In some instances following ACP affiliation, the patient responded with an upgraded agreement suggesting that, from the patient's perspective, the ACP had fully understood their situation. Along with progressivity, which generally followed ACP's affiliative turns, such interactional features suggest the ACP's responses displayed social solidarity (Lindstrom and Sorjonen, 2013). Whether such social solidarity alleviated patient suffering cannot however, be confirmed from these data. However, findings from analysis of ACP responses to patients' problem-tellings start to suggest that establishing what compassionate talk looks like, under these different circumstances, is not straight-forward.

Analysis of ACP responses to patient problem-tellings suggest that, in settings such as HCOP, there may be circumstances where the alleviation of physical suffering may not be possible e.g. managing shortness of breath and showering. Acknowledgement of suffering through affiliative practices may offer social solidarity. However, in circumstances where there is no way for the ACP to alleviate physical suffering, my analysis does raise questions about whether we can distinguish between empathy and compassion interactionally. Where ACPs affiliate with the patient's feelings, they are providing what Hepburn and Potter (2007) describe as empathy or "a formulation of the (patient's) mental state" (p.102). And while in extracts where the ACP affiliates with the patient's stance that a situation is hard or unpleasant, they may not be displaying the explicit understanding of the patient's feelings that is typically associated with empathy, the ACP is still displaying an understanding regarding the patient's situation. The current findings suggest that, in relation to interaction, distinguishing compassion from sympathy and empathy is problematic. If there are problems defining the parameters of each, questions emerge about how generic recommendations regarding compassion can be applied to settings such as HCOP.

While the analysis presented here suggests that ACP affiliation and displays of understanding are important in compassionate responses to patient problems, it also identifies that these actions occur within a context of concurrent and competing institutional demands. These competing demands mean that responses in the problem-telling sequence require sensitivity. Firstly, there was

some evidence that participants' responses oriented to the maintenance of 'face' (Goffman, 1955), particularly the patients. When affiliating or displaying understanding, ACPs tended not to explicitly expose the patient's limitations. Secondly, although patients display their stance towards a problem during a telling, ACP displays of understanding of the patient's feelings or concerns frequently involved come sort of candidate understanding (or guess). As only the patient has access to their feelings, there is the potential that the ACP's candidate understanding could be incorrect. There is also the issue that the patient has primary epistemic rights over their own thoughts and feelings (Heritage, 2011; Heritage and Lindstrom, 2012). To declare with certainty what another is thinking or feeling risks denying the patient these rights. Features of ACP responses to patient problems, including the use of questions rather than assertions, and downgrades which allow the patient to easily reject the ACP's understanding, orient to the patient's epistemic rights. This orientation to 'face' maintenance and the preservation of the patient's epistemic rights suggest that, in addition to acknowledging and displaying an understanding of suffering, ACPs may also be orienting to the provision of respectful dignified care, which is another means through which to prevent harm (or suffering). Within the environment of healthcare of the older person, where functional abilities may be in decline, maintaining the patient's rights to their own beliefs and feelings, and a positive self-image may be particularly important.

In addition to suggesting that ACP responses to patient's problem-tellings are managing a number of competing demands, the chapter also shows how delicate and context responsive the acknowledgement of suffering is, and this begins to illustrate the limitations of checklist approaches, or generic recommendations regarding the enactment of compassion. Firstly, there may be instances where an ACP displays practices which policy and research suggest are compassionate, for example, the listening and shared decision-making which policy identifies as compassionate (see Commissioning Board Chief Nursing Officer and DH Chief Nursing Advisor, 2012), but the ACP may be held accountable for a lack of affiliation and/or a clear problem solution (see extract 5.4). Secondly, as discussed in the previous paragraph, I suggested that ACPs may not display explicit empathy, which policy (Commissioning Board Chief Nursing Officer and DH Chief Nursing Adviser, 2012) and previous research (Sinclair *et al.*, 2016a; van der Cingel, 2011) suggests is a component of compassion, in order to preserve the patient's dignity. This reinforces the

suggestion that checklist training and assessments in relation to compassionate interaction may actually be unhelpful and counter-productive in certain contexts.

In the subsequent analysis chapters, further consideration will be given to both how context influences displays of compassion and the interplay between delivering clinical care, responding to suffering and the prevention of harm.

Chapter 6 Analysis: Patient complaints and ACP responses

6.1 Introduction

In Chapter 5, analysis focused on patient problem-tellings and ACP responses. In this chapter a specific action that can be performed by patient problem-tellings is focused on – patient complaints. The chapter focuses on a number of different types of complaint, including complaints about the ACP's talk or embodied actions that occur during the course of the interaction, complaints about care outside the immediate ward, and complaints about care by other staff members on the ward. Analysis focuses on the complaint, the ACP's response to the complaint and the patient's subsequent talk. I will show how ACP responses vary according to the context and that, in certain circumstances, there may be good reasons not to affiliate with a patient complaint. First, to contextualise findings, I will provide a brief summary of previous conversation analytic work on complaints in everyday and healthcare interaction.

6.2 Background

6.2.1 Complaints-talk

The term 'patient complaint' is typically used in healthcare to describe the formal communication of a clinical, managerial or relational failing in service provision, which seeks an institutional response (Gillespie and Reader, 2018; Reader, Gillespie and Roberts, 2014). The present chapter adopts an alternative understanding of 'complaint', derived from previous conversation analytic work. Rather than formal complaints, which are usually in writing, the understanding of complaint used in this chapter is perhaps more akin to the 'complaining' people do in everyday life[28]. As Drew (1998) suggests, a complaint in talk includes a report of others' conduct:

[28] There is no evidence that the complaints raised and ACP responses relate to or resulted in formal complaints.

"through which we recognizably display an action's (im)propriety, (in)correctness, (un)suitability, (in)appropriateness, (in)justice, (dis)honesty" (p.295).

Similarly, Ruusuvuori and Lindfors (2009) suggests that a complaint in talk displays a negative stance towards some target, which has resulted in the complainant reportedly being inappropriately treated. The latter definition is broader, with the objects targeted extending beyond others, to include institutions and activities. Both these definitions of a complaint differ from those of a problem, with a complaint describing a transgression, which results in inappropriate treatment of the speaker. While the object of complaints can be third parties (Drew, 1998), they can also refer to a transgression the recipient of the complaint makes during the ongoing interaction (Dersley and Wootton, 2000; Schegloff, 1988).

Previous conversation analytic research has focused on how complaints in talk are recognised and receipted. Different practices speakers use to construct explicit complaints include:

1. Negative assessments/observations e.g. "you didn't get an ice-cream sandwich" (Schegloff, 1988).
2. Extreme case formulations e.g. "it was brand new" when complaining about damage to an item of clothing (Pomerantz, 1986).
3. Idiomatic expressions e.g. "it's like banging your head against a brick wall" (Drew and Holt, 1988).
4. Reported speech – in comparison to an explicit negative assessment, reported speech gives the recipient access to the event and allows them to react e.g. "so I went over to him and I said, I've got a bill here for fifty quid. He says, Oh I'm sorry it's nought to do with me" (Holt, 2000).
5. Reported thought – provides an evaluation of the reported event. Gives the recipient guidance on how to evaluate the telling e.g. "I thought that …" (Haakana, 2006).

While the practices listed above may indicate the presence of a complainable matter, like troubles-tellings, explicit complaints about third parties are achieved collaboratively through an extended sequence of talk (Drew and Walker, 2009). In a manner similar to a troubles-telling, the initiation of a complaint sequence begins with an introduction or announcement (Drew, 1998). This topicalizing of the complaint may be done cautiously or implicitly, orienting to the complaint's

delicacy and the need to secure the recipient's participation in the complaint (Drew and Walker, 2009). As Mandelbaum (1991) shows, speakers can design complaints so that it is possible for the recipient to disattend them and, for example, take up another topic embedded in the turn. The recipient therefore does not have to disagree or be complicit in a complaint about another. A recipient disattending a complaint does not however mean that the complainant will not pursue the complaint (Ruusuvuori and Lindfors, 2009).

In everyday interaction, Drew and Walker (2009) show how recipient affiliation can escalate a complaint. During a complaint sequence, the recipient of a third-party complaint may expand the complaint-telling, essentially joining in the complaint, with the identities of the complainant and recipient becoming unclear. Unlike formal complaints in healthcare, which are concerned with seeking a formal response or resolution, complaints in everyday interaction are not necessarily about resolving the complaint, but about relational work such as seeking affiliation and cementing relationships (Drew, 1998). As with troubles-tellings, the sequence is however, likely to be influenced by local and general contingencies, and there is some evidence of these contingencies in previous conversation analytic work exploring complaints in healthcare encounters (see Ruusuvuori and Lindfors, 2009).

6.2.2 Complaints in healthcare encounters

Previous research suggests that when patients raise complaints about previous treatment by a third-party, during primary care consultations, they also orientate to the institutional context in which the interaction occurs (Ruusuvuori and Lindfors, 2009). The patient's complaints tend to have a specific purpose within the institutional encounter, and they are introduced in a way that allows the healthcare professional (GP) to move the talk towards ongoing business, without having to affiliate or disaffiliate. Ruusuvuori and Lindfors (2009) show that patient's complaints are often incorporated into talk about health-related problems (see extract 6.1 below) and formulated in ways which avoid explicit accusation.

Extract 6.1 "She didn't prescribe anything"[29]

(Ruusuvuori & Lindfors, 2009, p.2424)

1	Pat	I've actually co[me now because she didn't prescribe=
2	GP	[Hm
3	Pat	=anything as [I've usually had< tha:t ECG?
4	GP	[Mm,
5	GP	Ye[s?]
6	Pat	[and then I have those blood tests.=
7	GP	Right okay: .hhhhh (and) I looked at that a little bit

As extract 6.1 shows, patients use complaints as a method for justifying visiting the GP and, in this extract, the GP receives the complaint as an adequate account, with the doctor moving to the examination phase of the visit. The complaint therefore remains embedded in the problem presentation and the GP does not have to affiliate or disaffiliate with the complaint. Ruusuvuori and Lindfors (2009) suggest this is because the patient is oriented to the institutional task, even if the patient's problem presentation may forward other "(implicit) personal projects" (p.2426), such as complaining. Explicit complaints by patients about another health care professional are rare, and Ruusuvuori and Lindfors (2009) show the consequences of patients pursuing a complaint, despite only alignment and minimally affiliative responses from the GP. In an extended example, over sixty lines of transcript, overlapping talk is frequent and both the patient and GP repeat their stance. The complaint is about the patient being told she was not eligible for a treatment, and the patient says twice – "everybody was surprised at how nurses can talk in that way". In comparison, the GP attributes blame to both the nurse and patient, repeating that there has "been some kind of misunderstanding". Based on their analysis, Ruusuvuori and

[29] In lines 1 and 3 the patient constructs a complaint using the negative formulation "she didn't prescribe anything". The patient's talk also provides this complaint as the justification for the visit, prefacing the complaint with "I've actually come now because ..." (line 1). Following continuers which align with the patient's talk, the GP closes the problem presentation with "right okay" (line 7) and moves to examining the patient (Ruusuvuori and Lindfors, 2009).

Lindfors (2009) conclude that there may be good reasons for healthcare professionals to disaffiliate. They suggest that these reasons include the need to maintain the credibility of the institution, and working relationships with other professionals. While the definition of compassion in this thesis would suggest complaints should be responded to in order to acknowledge and alleviate suffering, Ruusuvuori and Lindfors's (2009) findings suggest this could be problematic. In healthcare of the older person inpatient settings there could be additional contributing factors. These may include distinguishing complaints that are part of a problem-presentation and explicit complaints, but they may also include gaining an accurate understanding of the complaint, especially when patients may be experiencing dementia and have talk which is hard-to-interpret.

6.3 Patient complaints about a current action by the ACP

6.3.1 Patient complaints about the ACP's embodied actions

As in findings from previous conversation analytic research in institutional settings (Ruusuvuori and Lindfors, 2009), data from ACP-patient consultations in healthcare of the older person suggests that navigating patient complaints is a delicate interactional task, with the actions of both the ACP and patient influencing the sequence of events. Before describing some of the complexities involved in third party complaints, which often occur over long sequences, and sometimes re-occur throughout an interaction, I will present two sequences where the patient complains about a current action by the ACP. In these cases, the ACP displays affiliation and the complaint appears to be resolved quickly. Extract 6.2 occurs during the opening of a consultation between ACP Sarah and Valerie, an eighty-nine year old, admitted to hospital with an infection. The patient's complaint is explicit and relates to the ACP's touch.

Extract 6.2 "Oh you're cold"

(CiP06 v.3 L1) Time 00:00

```
 1  ACP    ↑Morning (↑Val[erie.)
 2  Pat                  [Good morning.
 3         (1.4)
 4  ACP    Hello:.
 5         (0.3)
 6  Pat    How are you.     ((ACP sits on bed and l. hand touches
 7                          pat's r.arm))
 8         (0.4)
 9  ACP    I'm al[right.    ((ACP l.hand touches pat's r.arm))
10  Pat           [↑Oh: you're ↑col[d. (Oh ya)  ]
11  ACP                            [Uh I'm sorry] £↑I'm always↑
12         [cold.]£=
13  Pat    [ha   ]
14               ((ACP takes and squeezes pat's r. hand at sorry))
15  ACP    =h huh hu hu he .hhh  ((ACP lets go of pat's hand))
16  Pat    I used to be (0.2) but [I'm not     ] now.
17  ACP                           [>£↑Did ya?£<]
18  ACP    You're warm now.
19  Pat    <Y[es:.>
20  ACP      [Yeah
21         (0.2)
22  ACP    How are you:.
```

In extract 6.2 the ACP responds to the patient's "how are you" (line 6) with "I'm alright" (line 9) and a concurrent touch of the patient's arm (see image 6.1). An insertion sequence then occurs, with the patient saying "oh you're cold" (line 10). The "oh" is hearable as a response cry, perhaps conveying shock, and the "you're cold" conveys the reason for the shock. The ACP's response in line 11 shows that the patient's negative assessment is received as a complaint. The ACP apologises ("I'm sorry", line 11) and then gives an account "I'm always cold" (line 11-12). The ACP not only affiliates with the patient's stance, she also take full responsibility for the action and the patient responds with a my side-assessment (Heritage, 2011) ("I used to be", line 16). Although followed by the contrastive "but I'm not now" (line 16), the patient's turn appears to do affiliative work, sharing some understanding about what it is like to be cold.

Image 6.1 "Oh you're cold"[30]

ACP: How are you.

ACP: I'm sorry

As in chapter 5, the ACP shows awareness of the patient's suffering, and the patient's response suggests that the ACP's affiliation and acknowledgement of responsibility is accepted as adequate. While the complainable matter may appear a relatively minor transgression, and could potentially have been ignored, the ACP's response suggests that ACPs do acknowledge suffering that occurs during the interaction. Previous research exploring patients' experiences and perceptions of compassionate care have referred to 'the small acts' (Bramley and Matiti, 2014; Straughair, Clarke and Machin, 2019). When a patient complains about a minor transgression, which occurs during the course of the interaction, affiliating with, accepting responsibility for, and apologising for any resulting suffering, is an example of how doing the 'small things' occurs during ACP-patient interaction, and how detailed interactional study can shed light on some of the specific processes involved.

6.3.2 Patient complaints about the ACP's talk

While extract 6.2 shows a complaint about the ACP's embodied action, extract 6.3 shows a complaint about the ACP's talk – an assessment of the patient's pain. Extract 6.3 occurs seventeen minutes into a twenty-seven minute consultation between ACP Sarah and Pat. The ACP and patient have been discussing the patient's pain, and a hernia that may be exacerbating the pain.

[30] Where images are used in this thesis, written consent was given by all participants on the optional authorisation form (Appendix 11).

The patient has consented to an examination and, as he is getting on the bed, he produces a pain cry (line 1)

Extract 6.3 "Oh you're generous with my pain"

(CiP26 v.3 L642) Time: 14:47

1	Pat	[↑Ar:h. (s:hh) ((ACP picks up bed controls))
2		(0.2)
3	ACP	Are you <u>aw</u>right ↑there.
4		(.)
5	Pat	Ar:h >I shouldn't have< done <u>th</u>at.
6		(0.5)
7	ACP	Can I lift the <u>b</u>ed up? =↑Why does that <<u>hur</u>:t.>
8		((ACP looks to pat & starts raising bed))
9		(0.4)
10	Pat	◦#Ye<u>:</u>ah#◦ ((Pat. nods head))
11		(0.3)
12	ACP	<u>D</u>own <↑here.> ((ACP touches pat's r. groin))
13		(0.4) ((Pat. touches r. groin))
14	Pat	Here. ((Pat. moves hand to l. groin))
15		(3.2) ((Pat. moves hand across groin))
16	ACP	↑They <u>can</u> ↑be ↑pain:ful.((ACP puts bed control back))
17		(1.3) ((ACP removes stethoscope from around neck))
18	Pat	They ↑can ↑be <↑painful?> =Or: [you're £↑gen]erous with=
19	ACP	[I know I got]
20	Pat	=[my <u>p</u>ain.£ ((ACP leans towards pat))
21	ACP	[hu I kno::w >i<u>t</u> can be ↑very ↑painful.<
22		(0.5)
23	ACP	><u>When</u> <u>we</u> <u>worry</u> about them< is when they (0.2) we can't
24		(spec)(0.3) >when they won't< [re<u>d</u>]<u>uce:</u> and we can't (.)
25		sq[uash] them in >if=

Following the patient's pain cry (line 1), a question and answer sequence follows, in order to locate the patient's pain (lines 3-14). The ACP concludes the sequence with the assessment "they can be painful" (line 16). While the ACP's assessment provides medical confirmation that hernias can be painful, the patient does not receive the ACP's assessment of his pain as adequate. Firstly,

the patient responds with a repair-initiator - "they can be painful" (line 18). The exact repeat of the prior talk, delivered with raised pitch, suggests that the repair-initiator is addressing an issue with the acceptability of the ACP's assessment (Couper-Kuhlen, 2020; Svennevig, 2008). Secondly, the patient latches the ironic, negative assessment "you're generous with my pain" (lines 18 & 20). The negative assessment makes the complaint explicit, and the ACP's responses show that the patient's talk is received as a complaint. The ACP responds with a slow elongated "I know" (line 21), which affiliates with the patient's complaint about the ACP's understanding of his pain. Previous research has shown that "I know" does work to empathise and display an understanding of the speaker's stance (Mikesell *et al.*, 2017; MacMartin, Coe and Adams, 2014). Whether the turn displays the explicit understanding of the patient's feelings, which Hepburn and Potter (2007) define as empathy is debateable; however, the turn affiliates with the patient's complaint. Subsequently, the ACP repairs her talk using the upgrade "it can be very painful" (line 21). While not directly addressing the complaint, by using an upgrade to correct her previous assessment, the ACP implicitly acknowledges the patient's complaint that the ACP had minimised the patient's pain. The patient does not however, acknowledge the ACP's response, and following affiliating with the complaint the ACP returns to her 'no problem diagnosis' explaining when a hernia would be a cause for concern. Within the consultation extract 6.3 is taken from, it appears that the ACP and patient have conflicting agendas. The ACP's agenda on this specific occasion was to ensure the patient was medically fit to view a new property. The patient was reluctant to view the property, and had delayed the viewing previously due to pain. The lack of patient response to the ACP's self-repair "they can be very painful" may be because although affiliating with the patient's stance, the assessment does not acknowledge the seriousness of the condition for this specific patient or the patient's wider agenda. However, while there is no response from the patient in extract 6.3, in both extracts 6.2 and 6.3 when the patient complains about a transgression by the ACP, which occurs during the ongoing course of the interaction, the ACP affiliates with the patient's stance, the complaint is quickly resolved and the consultation proceeds. By affiliating and displaying an understanding of the patient's stance, the ACP is again acknowledging suffering and could be described as acting compassionately.

6.4 Patient complaints about care by third parties

6.4.1 Patient complaints about care by third-parties in another healthcare setting

In extract 6.2 and 6.3 an affiliative response to the patient's complaint, about the ACP's transgression, resulted in a rapid resolution. In extract 6.4, I will describe what happens when an ACP affiliates with a complaint about a third party, and the complexities this may present. The complaint occurs at the start of a ten-minute audio-recorded consultation between ACP Eve and Doreen, a ninety-one year old, who had been readmitted to hospital with shortness of breath, from a care home providing reablement[31]. The ACP had cared for the patient prior to her discharge and the consultation begins with the ACP asking, "what happened then?" The ACP's inquiry alerts the patient that she is aware of a possible problem, and her willingness to act as recipient (Jefferson, 1988). Following an insertion sequence, where patient and ACP talk about when exactly the patient was discharged, the patient commences a problem-telling, which includes a complaint about a member of staff at the reablement unit she had been discharged to

Extract 6.4a "It was just I got this man who didn't care"

(CiP24, v.3 L10) Time:00:09

1	Pat	↑Well the day I we:nt, (.) .hhh uh:rm: it was <very hot> th
2		That night.
3	ACP	↑A hu:
4	Pat	And erm tsk (.) .hhh I hadn't got my fan, (1.3) ↑I don't
5		know where that was, hh .hhh <uh:rm> (0.3) tsk (0.2) tsk
6		<he> hadn't got any oxy↑gen.
7		(0.2)

[31] A number of privately owned care homes in the local area were commissioned to provide reablement for patients who could be discharged from hospital but were not yet able to return home.

```
 8  ACP     ↓Mm ↑hm
 9          (0.5)/.hhh
10  Pat     And I was fight↑ing↓ for my breath,=
11  ACP     =<↑O::[:h.>              ]
12  Pat           [<The <whole> night] long>=
13  ACP     =U::h:=
14  Pat     And he just <ignore::d me.> (0.3) He [really did.] .hhh=
15  ACP                                          [<~O::h~>  ]
16  Pat     =And at four o'clock he could see I was struggling. .hhh So
17          he fetched ↑his <super:ior> (0.2) tsk .hhh and she <ca:me>
18          (.) .hh and she was <love:ly> and she ↑said (.) .hhh ar:h we
19          bet:ter take your (0.4) blood pressure. (0.4) Well >of
20          course< that was <ri:ght (.) low.> (.) .hhh So she
21          immediately ↑sent for the paramedic.=
22  ACP     <◦Ye:ah.◦>
23          (.)
24  Pat     £And in next to ↑no time (.) .hh I'm back (.) here.£=
25  ACP     =↑So you didn't e: you must have gotten out, for abou:t
26          (0.7) what <fifteen ↑hours,> £or some↑thing£ ha .hhh huh .hh
27          >you weren't out for< you weren't even a <full> day out
28          were yu,
29          (0.5)
30  (??)    Tsk
31          (0.3)
32  ACP     <<Oh: ↑I'm [sorry.>>
33  Pat                [(No:.)]
34          (0.2)
35  Pat     .hhh <But> it was (0.2) the bad experience was <mine> with
36          the man .hhh who was in <↑charge.>
```

In lines 1 to 21 a patient problem-telling occurs with the patient explaining how she came to be readmitted to hospital. Embedded within this problem-telling is a complaint about a member of staff ("he hadn't got any oxygen", line 6, "And he just ignored me. (0.3) He really did", line 14). In addition to aligning with the patient's problem-telling, there is some evidence that the ACP affiliates with the complaint-telling. The ACP responds to the patient's complaint that "he just ignored me" with a slow, creaky voiced "oh" (line 15), which is delivered in a similar way to the patient's complaint. Responses delivered in a phonetically

similar way have been shown to be display affiliation (Couper-Kuhlen, 2012) and Heritage (2011) shows how 'oh' can be used to display empathic affiliation. Subsequently, the patient resumes her telling (lines 16 - 24) regarding how she came to be readmitted to hospital, and at the telling's end (line 24, "I'm back here"), the ACP seeks clarity regarding how long the patient spent outside of hospital (lines 25-8). When the patient's response to the ACPs "you weren't even a full day out were yu" (lines 27-8) is delayed, and a silence follows, the ACP offers an apology - "oh I'm sorry" (line 32). The slow delivery and emphasis in the ACP's apology, suggests a sympathetic response, which displays regret that the patient's discharge from hospital was unsuccessful.

In troubles-tellings affiliation usually moves a telling towards climax and ultimately sequence closure (Jefferson, 1988); however, as occurs in extract 6.4, recipient affiliation with a complaint can result in expansion of the complaint (Drew, 1998). The patient continues with the contrastive "but" (line 35), before stating that "the bad experience was mine with the man who was in charge" (line 35). In addition to Drew's (1998) finding that affiliation can result in complaint escalation in everyday talk, there may be other good reasons for the patient reissuing the complaint. Firstly, as Ruusuvuori and Lindfors (2009) show, patients in GP consultations use complaints as a means of accounting for the visit during the problem presentation sequence. The complaint could therefore account for the 'failure' of the discharge, with the responsibility for readmission directed at a staff member rather than the patient. Secondly, while the ACP's "oh" (line 15) appeared to affiliate with the patient's complaint, a more substantive form of affiliation, which Heritage (2011) shows is necessary for a response cry to be received as empathic, did not follow. In extract 6.4a, the ACP's subsequent apology appears related to the duration of the patient's discharge from hospital, whereas the patient's complaint was regarding 'the man in charge' of the reablement unit. As the ongoing interaction, in the extract below shows, the patient's complaint continues.

Extract 6.4b "It was just I got this man who didn't care" (continued)

(CiP24, v.3 L10) Time:00:09

Pat .hhh <But> it was (0.2) the bad experience was <mine> with the man .hhh who was in <↑charge.>
ACP <Ye[ah::>]
Pat [>I mean] they< had the (0.2) .hhh <the actual ro: (0.2) the actual ho:me> (.) ↑is fine.>
(.)
ACP <◦Ye:a[h.◦>
Pat [↑It was just that I got ↑this: .hhh <man who just> (0.2) didn't care:.
(0.3)
ACP <↓Mm.> [That's there's no ex]↑cuse for that really=
Pat [He just didn't care.]
ACP =is [<there.> =There's (not an excuse) for]
Pat [No. N: no ↑he was he was not] in the right job. .hhh ↑Oh >and it< (.) .hh I hadn't got a buzzer .hhh so I had to <↑shout> ↑s[omebody]
ACP [<O:h>] that's [a problem.]
Pat [So he <com]plained> that I was ↑shouting. (0.6) tsk .hhh >I thought< well how do you make [anybody an] (0.3) ↑you know [>hear if you<]
ACP [↑How <↑ru:de.>] [(<Yeah>)]
Pat = (0.2) .hhh if=you haven't got a buzzer but (0.3) tsk .hhh <it was just ↑it was just one of [those things.]
ACP [Unpleas]ant.=
Pat =.hhh But (.) I don't think I'll go back there.=
ACP =<I think we get that h:[huh h: ha £We get that impression=
Pat [I think ( ) £I think I'll give=
ACP =it's ↑okay£]
Pat =that one a miss£]
ACP .hhhh <A[rh> I'm really sorry it didn't work out that]=
Pat [Yeh I'll give (.) give that one a miss]
ACP =way:.
ACP [Uh:rm]
Pat [Never] mi:nd.
ACP Tsk .hhh We've been ↑tinkering around with your: ↑water tablets again though ↑haven't we.

While the ACP's affiliation in line 32 appeared to relate generally to the patient's readmission, following the patient stating that the bad experience was hers with the man in charge, the complaint sequence builds gradually, with the ACP aligning as recipient (line 37) and the patient expanding her telling. When the patient explicitly complains in lines 42-3 ("I got this man who just didn't care"), the ACP aligns and explicitly affiliates with the complaint stating "there's no excuse for that really is there" (line 45). Whereas the ACP's earlier "oh" (line 15) may have displayed an affective stance regarding the patient's talk, this did not contain an explicit statement that the 'man' was wrong. Here, however, the ACP fully affiliates with the complaint, acknowledging that what happened was not right. Recipient affiliation can result in the continuation and expansion of a complaint (Drew, 1998; Drew and Walker, 2009) and, following the patient acknowledging the ACP's affiliation with "no" (line 48), and the evaluation "no he was not in the right job", the patient commences a new but related complaint ("oh … I hadn't got a buzzer so I had to shout somebody" line 49-50). Throughout the complaint-telling that follows the ACP affiliates, firstly, taking the stance "that's a problem" (line 51). Secondly, following the patient expanding her complaint-telling ("so he complained that I was shouting", lines 52-3) and commencing talking about her reported thoughts at the time (lines 53-6), the ACP responds with the assessment "how rude" (line 55), which expresses indignation on behalf of the patient. Finally, as the patient appears to be exiting the complaint with "it was just one of those things" (line 57), the ACP responds with "unpleasant" (line 58). From here, talk turns to the patient not wanting to return to the reablement unit, before the ACP offers the affiliative "Arh, I'm really sorry it didn't work out that way" (line 64) and the patient responds with what Jefferson (1988) describes as the closure implicative "never mind" (line 68).

As discussed in relation to patient problems-tellings (Chapter 5), when the ACP affiliates with a patient complaint they could be described as acknowledging suffering. Affiliating with a complaint also provides an opportunity for the patient to expand the complaint and, in the case of extract 6.4b, for the patient to state what she wants to happen to prevent further suffering – not to return to the reablement unit. In extract 6.4, the complaint is however, about a staff member at a reablement unit, which the patient will not return to and the ACP will have no direct contact with. There are therefore limited consequences of fully affiliating with the patient's complaint and taking a stance on the

unacceptable level of care delivered. In contexts where the complaint is about a colleague or the delivery of care in the current healthcare setting, explicitly affiliating with a patient complaint, without mitigation, may present difficulties for ACPs.

6.4.2 Patient complaint about future care - based on previous experience

In both patient complaints about the ACP's talk or embodied actions, and talk about third parties outside the current care environment, ACP affiliation was evident. Different ACP responses were however, identified when patient complaints concerned third parties on the ward where the consultation occurred. As in extract 6.5 below, the patient complaint could remain implicit, with the ACP and patient pursuing different projects. Extract 6.5 starts two minutes forty-five seconds into a twenty-minute consultation between ACP Sarah and Doreen, a ninety-one year old, admitted to hospital following a blackout. Sarah and Doreen had previously met, during the patient's fourteen-day hospital admission. The patient complaint occurs during talk about cannulation for an iron infusion. The patient is reluctant to be cannulated, and raises complaints about previous cannulations. Unlike other extracts, the complaint relates to an event the ACP is going to perform in the future – cannulate the patient.

Extract 6.5a "I was a patchwork quilt"

(CiP21 v.3 L109) Time 02:45

1	ACP	And ↑er: w so we're just <waiting,> (.) cos we >need to give
2		you< a second dose of your iron ↑transfusion.
3	Pat	↑I know.
4		(0.6)
5	Pat	(↑I hope) (0.2) ↑it'll have to be ↑tablet form I think,
6		won't it,
7		(0.2)
8	ACP	Well w (0.2) we're going to <↑tr:y>
9		(0.5)
10	Pat	<Oh no:.> (0.2) .hhh ↑I was a ↑patch:work quilt.
11	ACP	<↑We really need t. =↑I kn:ow:.>=
12	Pat	=↑I know but [↑he ↑even] ↑tried that [little] ↑finger,

13 ACP [Would yu] [↑Okay.]
14 (.)
15 ACP Oh ↑no. (0.2) Real:ly,
16 Pat ↑Mm:
17 (0.8)
18 Pat ↑They were so de[sper(ate)
19 ACP [WOULD YOU ALLOW US to <try> again, because
20 it's the [that's the best]

In lines 1 and 2 the ACP informs the patient about an iron infusion, which is to be administered intravenously. Following a short insertion sequence about the method of administration (lines 5-8), the ACP confirms "we're going to try" (line 8). The patient responds with distress to the information ("oh no", line 10), and then justifies her distress stating "I was a patchwork quilt" (line 10). Idioms are one means of complaining, used in everyday talk when there is conflict or a lack of affiliation (Drew and Holt, 1988). In comparison to alternatives, such as "I was a pin cushion" or "they have stuck them everywhere", the use of "I was a patchwork quilt" is ambiguous. While clearly identifying the problem, the complaint is implicit and does not specify who is responsible for the unsatisfactory state of affairs – the patient's veins, the staff who have previously attempted to cannulate the patient, or the ACP who is going to cannulate the patient again. Initially, the ACP responds with an account for why the patient's dispreferred action needs to happen ("we really need t", line 11), before displaying an understanding of the patient's negative stance - "I know" (line 11). 'I know' has been shown to be one method of displaying empathic understanding during veterinary consultations (MacMartin, Coe and Adams, 2014). The delivery of the turn also conveys that the ACP is displaying an understanding of the distress cannulation causes the patient. The use of "patchwork quilt" as a metaphor, because of its lack of specificity, allows the ACP to align and affiliate without apportioning blame (to other staff).

Following the ACP's affiliation, the patient acknowledges the importance of the infusion with "I know" before complaining "but he even tried this little finger" (line 12). The turn conveys that the patient is not objecting to the treatment per se, nor objecting without good reason grounded in prior experience. However, the extreme case formulation "even tried" and "little finger" are complaint implicative (Pomerantz, 1986). While in overlap with the patient's

telling about the previous attempt at cannulation, the ACP appears to start seeking permission for the iron infusion, the turn is abandoned and following a micropause (line 14) the ACP aligns responding "Oh no (0.2) really" (line 15). While receiving the information that staff tried to cannulate the patient's little finger as news, "oh no" also affiliates with the patient's stance that trying to cannulate the patient's little finger is not an ordinary or desirable state of affairs. The use of "really" by the ACP also conveys shock or surprise and the patient confirms the account about where cannulation was attempted in line 16 ("mm:"). Following a silence, the patient continues her account stating "they were so desperate" (line 18). However, the focus of the patient's account seems to change. Rather than complaining about previous staff's attempts at cannulating, or the personal distress caused by this, the patient's turn focuses on difficulty for staff. The patient is displaying the impossibility of the procedure, drawing on shared knowledge that the little finger is not a desirable place to cannulate. Therefore, while the patient does complain during extract 6.5, she is also building a case for why she is reluctant for cannulation to be attempted again. The complaint is therefore more about a general situation than a specific member of staff, and may explain why the ACP affiliates in lines 11 and 15.

The patient complaint in extract 6.5 continues as follows:-

Extract 6.5b "I was a patchwork quilt" (continued)

(CiP21 V.3 L109) Time 02:45

18	Pat	↑They were so de[sper(ate)
19	ACP	[WOULD YOU ALLOW US to <try> again, because
20		it's the [that's the best]
21	Pat	[<↑Well ↑I'll ↑have] ↑to:> but, (1.0) u u hi: .hh
22		(0.4) ↑it's (0.3) £hhh I d hhh£ ↑disappointing when (.) .hhh
23		I've ↑nay even got the .hh [hh ↑I'm] sure he was hhh ↑a man=
24	ACP	[◦◦No:◦◦]
25	Pat	=that (0.3)(just) ↑specialised in it, hh and he came down be
26		(1.1)
27	ACP	Oh: [yes]
28	Pat	[( )] .hh[h ↑And
29	ACP	[>He's not well< yeh.

30 Pat ↑He was <↑trac↑ing>
31 (0.4)
32 ACP ◦Yeh◦=
33 Pat =↑The vein.
34 (0.3)
35 ACP [Ye:ah
36 Pat [.hh Once he'd <got it.> =He was ↑tracing where it went .hh
37 to ↑see if there was a .hhh >a ↑space where he could get the
38 cannula in.<
39 (0.2)
40 ACP Mm:.=
41 Pat =There ↑wasn:'t. (0.3) .hhh No ↑so that didn't work. .hh
42 ↑And in the end: <I think ↑they .hh ↑taped one in some↑how>
43 (0.4)
44 ACP ↑They got it in.
45 Pat .hhh ↑And they got <the ↑stuff> in: but it ↑fell out
46 immediate:ly
47 ACP Hu hh hur That's [all we need] it in for though isn't=
48 Pat [But they]
49 Pat =They have:n't ↑tried again y:et.
50 (0.2)
51 ACP No. (0.3) So we have to wait a week (0.2) <betwe:en> (0.3)
52 [doses.]
53 Pat [<Right,>] (.) right right=
54 ACP =I will t (0.2) try I'll ↑try here cos >these are< the
55 better vei:ns, cos it's only (.) for fifteen
56 <minutes::.>=>It just means you have to< keep <your arm>
57 straight for fifteen minutes.
58 (0.9)
59 ACP It's probably an easier vein to try and <ge:t in: to.>
60 (0.3)
61 ACP If ↑we ↑can't we can:'t. (1.1) <But would you allow us to
62 have a go:?>
63 Pat .hhh <Of cour:se>

As already discussed, implicit affiliation such as "oh no" appears to require more substantive affiliation later in a sequence to be accepted by the recipient (Heritage, 2011). However, explicit affiliation does not occur in this sequence and, in overlap with the end of the patient's claim that staff were "desperate", the ACP commences the request "would you allow us to try again?" (line 19). The patient begrudgingly agrees (line 21), before commencing a problem-telling about the last cannulation (lines 22-46). Following talk from the ACP about why it is usual to wait a week to give the second iron infusion (lines 47-52), the ACP explains what she will do in lines 54 to 57. While there is no explicit acknowledgement of a patient complaint within the ACP's explanation of the proposed action, the ACP does clearly acknowledge some of the objections the patient has raised in her telling. The ACP explains that she will try "better veins" (line 55) and "easier veins" (line 59), suggesting that there are preferential options to those performed for the previous cannulation (although it is also acknowledged that the patient will have to keep her arm straight for fifteen minutes (lines 56-57)). Ultimately, the ACP reissues her request to cannulate (lines 61-62), and the patient agrees (line 63). While there is some implicit affiliation with the complaint early in extract 6.5a, and the ACP's informing about what she will do relative to what has been done before acknowledges the patient's concerns, the ACP avoids explicitly affiliating with possible complaints or objections about cannulation. To explicitly affiliate may have resulted in escalation of the complaint (Drew, 1998) and the patient refusing the iron infusion. In the long-term refusing the iron infusion may have resulted in the patient experiencing more symptoms of anaemia alongside side-effects from oral iron medication. While the ACP hears the patient's complaint, informing the patient how the cannulation will be performed differently, the ACP does not fully attend to the complaint in the service of necessary clinical care.

6.4.3 Patient complaint about current care by third parties

While in extract 6.5 the patient complaint remained implicit, with talk focusing on the proposed cannulation, in extract 6.6 the patient raises an explicit complaint and the ACP affiliates. However, mitigation is also evident in the ACP's talk. The extract is taken from a five minute thirty-six second interaction between ACP Rich and Mrs Williams, a ninety-two year old, admitted to hospital

from a care home following a fall, eleven days before the consultation. Rich and Mrs Williams have previously met, and the complaint occurs two minutes forty-seven seconds into the consultation. Following an opening where the patient reports that she did too much the previous day, and discussion about a scan that is outstanding, the ACP commences assessing the patient's pain (line 1)

Extract 6.6 "Oh gosh it hurt me"

(CiP12, v.3, L.87) Time: 02:47

```
ACP     How's your pain doing when you're just >lying in bed< like
        this normally.
        ((ACP raises r. index finger.  Pat raises hand.  Touch on
        'doing'.))
        (0.6)
Pat     U (.) well I'm alright, (0.4) until they (0.4) try to say
        (0.4) ↑turn↑o:[ver
ACP                   [Over.
        ((ACP turns head away as says 'over'))
        (.)
Pat     And I ↑don't and they push me. =↑Oh:: ↑gosh it hurt me.
        ((ACP takes pats hand and brings towards him.  ACP puts
        head in arm))
        (0.3) ((ACP lifts head))
ACP     ◦↑Yes <I am sor:ry about that>◦ (0.4) Yeah it's uhrm yes
        (2.0) sorry about that <it does happen
        every[where> I'm afraid. (1.0) [Uhm  ]
Pat          [(unclear               )([Don't] say it's happening
        to us all.)
        (0.9)
ACP     <Are ↑you happy> with the painkillers that you're on.
```

The ACP's initial question acknowledges that the patient is experiencing pain, but asks specifically about the pain when the patient is "just lying in bed like this normally" (line 1). The patient commences her response with "well" (line 6), suggesting that her answer may not be straightforward (Schegloff, 2005), or that she is about to produce a dispreferred answer (Pomerantz, 1984a). The patient's answer suggests that there is a problem - "I'm alright until they try to

say turnover" (line 6-7). Reported speech can be one method of doing complaining (Holt, 2000) and saying "they try to say turn over" (lines 6-7), rather than 'it hurts when I turn over', indicates that a complaint-telling may be developing. Quotation markers indicating reported speech, such as "they try to say", can also assist in projecting when a turn is about to end (Lerner, 1991) and, in line 8, the ACP collaboratively completes the turn saying "over". Collaborative completions are one method for displaying understanding of both a participant's stance and the action-in-progress (Bolden, 2003). The ACP displays understanding that the patient is experiencing pain, when she is assisted to move, and the patient then expands her complaint-telling - "and I don't and they push me. Oh gosh it hurt me" (line 11). The patient has already used reported speech (line 6-7) and, within the context of being moved, 'pushing' could be regarded as an extreme case formulation. Along with the upgraded consequences of the staff's actions "oh gosh it hurt me" (line 11), all indicate that the patient is constructing a complaint, and the ACP's response supports this. Embodied actions show the ACP putting his head in his arms, as if in a mock display of shame. The ACP then affiliates, directly addressing the complaint with an apology, "yes I am sorry about that" (line 15). There is a short silence, during which the patient does not respond to the apology, and the ACP continues his turn with self-repair and hesitation ("Yeah it's uhrm yes (2.0)", line 15), suggesting a difficulty or delicacy in continuing. Ultimately, the ACP offers a mitigated apology - "sorry about that it does happen everywhere I'm afraid" (line 16-7). While apologising, the ACP attempts to account for the "pushing" in order to turn someone over, stating "that it does happen everywhere" (lines 16-17), before tagging "I'm afraid" (line 17). The ACP therefore takes the stance that turning patients is commonly difficult but inevitable. While the patient's subsequent talk occurs in overlap and is difficult to hear, if the patient's response is "don't say it is happening to us all" (lines 18-19), the patient appears to resist the ACP's mitigation. Certainly, the patient displays a negative stance towards the ACP's claim that 'pushing' is widespread.

Following the patient displaying a negative stance towards the ACP's mitigation that pushing happens everywhere, a silence occurs before the ACP changes the topic to pain control. The patient's complaint about 'being pushed' is not raised again, suggesting that the topic is adequately resolved. In extract 6.6, the patient's complaint is a generalised complaint about a fundamental care activity and the ACP essentially affiliates regarding the distress pushing causes, but he

also claims that turning is a necessary activity and acknowledges that pain may be an inevitable part of this.

6.4.4 Repeated patient complaint about current care by third parties on the hospital ward

In the majority of extracts discussed so far, ACPs have either explicitly affiliated with the patient's complaint, usually via an apology, or displayed some kind of understanding regarding the consequences for the patient. As the complaint is not raised again, the complaint appears to be resolved from the patient's perspective. The final extracts will present data from one consultation, where the patient repeatedly raises the same complaint – rough handling ('throwing') by staff, when being assisted to move. The extracts are taken from an eleven-minute consultation between ACP Sarah and Marilyn, a ninety-nine year old patient admitted following a fall. The patient also has hearing loss, and is having difficulty swallowing (clearing secretions), which would later be confirmed to be the result of a stroke. As a result, there are a significant number of repairs during the extracts and the patient's speech is consistently creaky/moist. The patient also has a diagnosis of dementia. What impact cognitive impairment has on the sequences to be discussed is unclear. Raising the same complaint repeatedly is unusual in the data set analysed, however, as will be shown, the presentation of the patient's complaint and the ACP's response changes with each iteration suggesting that the complaint remains unresolved.

The patient's first explicit complaint about assistance with moving occurs two minutes thirty-two seconds into the consultation. Prior to extract 6.7, the ACP has been assessing the patient, including the patient's 'drooling'. The patient has also raised concerns about nightmares. Extract 6.7 begins where the ACP commences questioning the patient about coughing.

Extract 6.7 "They threw me over"

(CiP15, v.3. L.106) Time 02:32

1	ACP	[<Have you] ↑been <COUGHing> at: all::.>
2	Pat	[(#That's it#)]
3		(0.2)
4	Pat	Yeh
5		(0.6)
6	ACP	O:[kay
7	Pat	[(unclear) (0.4) (and/I had) these: <ribs.>
8		((Pat. touches ribs))
9		(0.4)
10	ACP	How long have you had the <cough> for:
11		(1.4)
12	Pat	#↑Ever since they threw me over.# ((Pat. action with hands))
13		(0.6)
14	ACP	They ↑threw ↑you ↑over,
15		(0.2)
16	Pat	#Yeah#
17		(0.9) ((ACP moves arm towards pat. leg))
18	Pat	#To get me from ↑here onto = ((Pat action with hands))
19		=[the bed.#]
20	ACP	[Arh okay.] (.) ↑Are you coughing any:thing up.
21		(1.6)
22	Pat	No
23		(0.2)
24	ACP	Okay (.) Can I have a little listen to your chest

Following the ACP asking the patient whether she has been coughing, the patient provides an affirmative answer (line 4), adding additional information about her ribs (line 7). The ACP continues questioning about coughing, asking the patient: "how long have you had the cough for?" (line 10). Rather than giving a specific time, the patient reports that she has been coughing: "ever since they threw me over" (line 12). Not only does the patient respond to the time element in the ACP's question about coughing, she also uses the extreme case formulation "throwing" to introduce a complaint – that someone has been throwing her. Following a pause, the ACP responds with the repeat: "they threw you over" (line 14). Repeats following an answer can perform a number of

different functions including other-initiated repair, which addresses problems with hearing, understanding or the action being performed in the previous turn (Couper-Kuhlen, 2020; Robinson and Kevoe-Feldman, 2010), and ritualised disbelief (Wilkinson and Kitzinger, 2006). Ritualised disbelief receipts prior talk as news to the recipient, and invites a response (Heritage, 1984a). In line 16, the patient confirms the ACP's candidate hearing with a "yeah", before providing an expansion: "to get me from here onto the bed" (line 18). As well as the possibility of the ACP expressing disbelief, the possibility that she has not understood the patient's reference to throwing also requires consideration. Recent research on interaction between professionals and atypical populations has shown that professionals use both news receipts and repeats to pass over talk that is not understood, in the hope that intersubjectivity will be restored later, and the participant's 'face' will be maintained (Pilnick *et al.*, 2021). While the ACP may not have understood the patient's reference to 'throwing', and therefore may be passing over a loss of intersubjectivity, her repeat avoids affiliating with the patient's complaint and ultimately the complaint sequence ends. The patient's expansion "to get me from here onto the bed" (line 18) no longer contains a complaint and, in line 20, the ACP responds with the news receipt "arh okay". News receipts show that the recipient is now fully informed, and there may be no need for the informer to provide further information (Heritage, 1984a). Certainly following the ACP's news receipt she resumes the clinical assessment.

Throughout the chapter on problems, and extracts in this chapter, I have shown how affiliation with a problem or complaint displays an acknowledgement of the patient's suffering. However, in extract 6.7, the ACP does not facilitate continuation of the complaint story or affiliate with the patient. The ACP's response would appear contrary to research about compassionate interaction (see Figure 2.2) and managing complaints (van Dael *et al.*, 2020), both of which emphasise listening to and acknowledging patients. Affiliating in the present extract may however, have wider consequences. While the ACP may be able to provide more pain relief or propose that staff are gentle when they move the patient, she cannot prevent the patient being moved. Immobility is associated with pressure damage (Bradford, 2016; National Institute for Health and Care Excellence, 2014), decrease in muscle mass and functional decline (Brown, Friedkin and Inouye, 2004; Smith *et al.*, 2020). Assisting patients with mobility, where required, is therefore a necessary component of fundamental care (Feo *et*

al., 2018). Potentially extending a complaint about care, which is inevitable and the ACP cannot resolve, could result in increased patient distress and suffering. Affiliating or agreeing with the complaint could also have a detrimental impact on relationships within the team and patient-professional relationships (Ruusuvuori and Lindfors, 2009).

Throughout the dataset, there was evidence of a number of possible patient complaints that were not pursued and never raised again. As extract 6.5 showed some of these complaints may have been part of a wider patient project, such as resisting a treatment option, and following agreeing to the treatment the patient does not pursue the complaint. Following extract 6.7, the patient complains about 'being thrown' on three more occasions, with an ongoing shift in how the patient raises the complaint and how the ACP responds. The ACP continues to avoid explicitly affiliating with the complaint. Extract 6.8 occurs five minutes thirty-four seconds into the consultation. In the intervening time the ACP has completed a respiratory examination, the patient has expressed concern that her ribs may be broken and complained again about 'throwing'. The ACP has offered treatment recommendations, including pain relief prior to mobilising. Immediately before extract 6.8 talk has been about the patient's pain, with the ACP giving reasons for why the patient's pain needs to be controlled and how this will be achieved satisfactorily i.e. low doses so the patient does not become sedated (lines 1-3).

Extract 6.8a "As long as they don't throw me over"

(CiP15, v.3, L.239) Time: 05:34

```
 1  ACP     No exactly (.) but we'll try and make sure that it's <low
 2          doses>  of things so we won't (0.6) you won't
 3          [get se ↑sedated.    ]
 4  Pat     [#As long as you ()##]
 5          (0.4)
 6  Pat     #As long as they ↑don't throw me over.
 7  ACP     ((ACP nods head on over))
 8          (0.4)
 9  Pat     >Will [they do that<] do you think,
10  ACP           [<Yeah:.>     ]
11          (0.6)
```

```
12  ACP     Well we <↑hope no:t.>
13          (0.8)
14  ACP     We'[ll ask them  ] to [be <<gent:le.>>            ]
15  Pat        [#Well that's#]    [>#Well that's what they've ] been
16           doing.[And that's what's] caus(in) the ↑pain#
17  ACP             [  <°Righ:t.°>    ]
18          (0.6)
19  ACP     <°O:kay.°>
20          (1.7)
21  Pat     #A# [you don't know]
22  ACP         [Is ↑that when ] they're <chang:ing> you at nigh:t.
23          (2.8)
24  Pat     #↑It's not at nigh:t#
25          (0.4)
26  ACP     (Is) >In the< ↑when they get you up,
27          (0.2)
28  Pat     (#Yeh/here#) (0.7) When they <mo:ve me.> (0.4)
29          #Ye[h. >Getting<] getting# me mov (0.4) #get[ting ]=
30  ACP        [<O:kay.>    ]                          [Right]
31  Pat      =mobile.
32           (1.0)
```

Following the patient commencing and aborting a turn (line 4), in overlap with the ACP's explanation about how she will manage the patient's pain relief (line 1-3), the patient recommences her talk stating - "as long as they don't throw me over" (line 6). While the patient's turn presents an additional requirement, which is necessary from the patient's perspective, the repeat of the extreme case formulation also reintroduces the complaint. The ACP aligns responding with a head nod, in overlap with the end of the patient's turn, and a delayed "yeah" (line 10), which occurs in overlap with the patient pursuing the complaint – "will they do that do you think" (lines 9). The patient's question makes an answer from the ACP relevant (Schegloff, 2007). However, the question presents challenges, as is evidenced by the silence (0.6 sec, line 11). While any response that denies the 'throwing' implies disbelief, to answer the patient's question affirmatively would imply that the patient has been 'thrown' before, and affiliate with the criticism of staff. The ACP's response: "well we hope not" (line 12), attempts to navigate these challenges. While "well" projects that this is not the preferred answer (Pomerantz, 1984b), by focusing on her wishes or

desires ("we hope") the ACP avoids either explicitly affiliating or displaying disbelief. The long silence (0.8 sec.) following the ACP's turn, and the patient's expansion of the complaint ("well that's what they've been doing", lines 15-6) suggests that the ACP's 'hoping' is received as inadequate because 'throwing' has already occurred.

In addition to the patient pursuing her complaint (line 15-6), the ACP expands her turn adding a proposed intervention - "we'll ask them to be gentle" (line 14). This is the first time the ACP acknowledges that there are different ways in which staff can move patients (i.e. rough v. gentle), and the first time the ACP suggests an intervention, which may involve those who have been 'throwing' the patient. By formulating the turn as a future action to be managed, rather than a past action that needs addressing, the ACP again avoids explicitly affiliating with the complaint and attributing culpability to staff. As the solution offered occurs in overlap with the patient expanding her complaint-telling, there is a lack of clarity regarding whether the patient hears the option presented or 'passes it over' due to issues of acceptability. There is however, no acknowledgement from the patient of the ACP's offer to "ask them to be gentle". Instead, the ACP aligns as the recipient of a complaint-telling, responding with "right" (line 17) to the patient's claim that staff have been throwing her, and "okay" (line 19) following the patient's claim that this is what is causing her pain.

In the subsequent talk, a short history-taking section characterised by a question-answer sequence (lines 22-31), the ACP pursues the problem presentation - pain on movement - rather than the complaint. The patient clarifies that the pain is "when they move me" (line 28) and "getting mobile" (line 29-31), and the ACP again aligns as a recipient ("okay", and "right", line 30) before recommencing talk about problem-solutions (lines 33-34). As the continuation of the extract below shows, the recommendations are hearable as two separate actions. Firstly, "I'll ask them" (line 33) is a complete turn constructional unit, informing the patient of action the ACP is going to take (i.e. asking staff to be gentle when they move the patient). Secondly, the ACP proposes more pain relief before the patient is moved, tagging the question "don't you" (line 34), in an attempt to elicit patient agreement to the treatment plan.

Extract 6.8b "As long as they don't throw me over (continued)

(CiP15, 3.3, L.239) Time: 05:34

33	ACP	O:kay. (0.8) ↑I'll ↑ask them. (.) You perhaps need a bit of
34		pain relief before we get you up then ↑don't yo[u?
35	Pat	[<#Yeh#>
36		(0.2)
37	ACP	<Yea:[h>
38	Pat	[#Yes (it's) (0.5) (but it's just horrible). (0.4) >I
39		I<# (0.2) go to bed and think (0.5) #>Oh I hope I don't
40		↑have to go through it.<#
41		(0.2)
42	ACP	<A[rh::]really> then [you do need some more pain]=
43	Pat	[(I hope)] [(#It really is that bad.#)]
44		((ACP touches pat. leg))
45	ACP	=relief. You ↑need some more ↑pain relief: then. =↑We'll
46		get some more on board.
47		(.)
48	Pat	#Cos [(I can't) take take] this pain (of) (0.5) a:gainst=
49	ACP	[I wasn't aware of that]
50	Pat	my ribs.
51		(0.3)
52	Pat	They feel as if they're broken
53		(.)
54	ACP	Okay=
55	Pat	>Do you think they are<

The problem-solution the ACP has offered will potentially relieve pain and suffering, and the patient agrees with the treatment plan (lines 35 & 38). However, as was shown in relation to problems-tellings, a problem-solution may not acknowledge the patient's suffering (see extract 5.4) and in extract 6.8b the patient reintroduces the complaint, focusing on how the throwing affects her. Firstly, the patient produces an extreme case formulation "but it's just horrible", before sharing reported thoughts "I go to bed and think 'oh I hope I don't have to go through it'" (lines 38-40). The ACP's response "Arh really" (line 42) and the concurrent touching of the patient's leg, appears to respond to the patient's non-specific 'hoping that they don't have to go through it' with some sympathy.

Touch is described as a feature of compassion in qualitative interviews exploring compassion in nursing practice (Durkin, Jackson and Usher, 2021b). There is also evidence that touch is part of the multimodal practices which can be used to display emotions, empathy, and an orientation to the speaker's stance (Cekaite, 2020; Merlino, 2021). As previously discussed "arh" can be a practice for displaying empathic affiliation (Heritage, 2011). While the touch and "arh" may be displaying sympathy and empathic affiliation, the 'arh' is part of a longer turn-constructional unit – "arh really". 'Oh really' has been shown to be a change-of-state token, which suggests that the preceding talk is news to the recipient, and the recipient is now informed or knowledgeable (Heritage, 1984a). Certainly, the patient's response suggests that the ACP's turn has been received as a news receipt, with the patient confirming that "it really is that bad" (line 43).

At line 42 the ACP's turn does not finish with the aligning news receipt. The ACP continues her turn proposing "then you do need some more pain relief" (line 42). Essentially, the ACP acknowledges and moves the talk on to the problem-solution. Possibly because there is overlapping patient talk, the ACP repeats her turn (line 45) before continuing with "we'll get more on board." (line 45-46), which emphasises what can be done to alleviate the pain that arises from the care that is being complained about. Finally, the ACP states "I wasn't aware of that" (line 49). This turn emphasises that what the patient is saying (about unbearable pain when being moved) is news to the ACP, and potentially distances the ACP from any responsibility for the pain. That is, the ACP could not provide a problem-solution for a problem she was unaware of. While offering a problem-solution, there is again no affiliation or agreement with the patient's complaint about being thrown, and the patient resumes talking about whether her ribs are broken.

Affiliating with the patient's complaint in extracts 6.7 and 6.8 could, by implication, make the ACP complicit in criticising staff for moving the patient, and the extracts have shown a number of methods the ACP uses to avoid fully affiliating with the patient's complaint. These include treating the patient's talk as news, offering problem-solutions that focus on future action rather than historical complaints, and in extract 6.8 displaying sympathy regarding the patient's experience. While aligning with the patient and offering appropriate

clinical care, the ACP has not affiliated with the patient's complaint. As discussed in extract 5.4, however, a resolution that only addresses clinical care may not be treated as adequate by the patient. In relation to compassion, there appears to be a challenge between reconciling a short-term response that acknowledges the patient's suffering, and providing (or enabling the provision of) long-term care which may prevent further suffering. The ACP's responses are however, not received as adequate and the patient complains about being thrown, for a final time (Extract 6.9), approximately two minutes after extract 6.8 (eight minutes fifteen seconds into the consultation). In the intervening time topics discussed included the patient's ribs (and the patient's concern that they may be broken), pain, and the patient's drooling. Extract 6.9 differs from the previous extracts, in relation to the distress the patient shows about 'being thrown'. The extract begins with the patient initially complaining about her pain.

Extract 6.9a "It's the throwing"

(CiP15, v.3, L.368) Time 08:15

1	Pat	##>It's n it's not<## I'm: not (0.2) the pain itself is
2		terrib[le. =It's the] throwing ((Pat. brings clenched fist
3		down))
4	ACP	[<I know>]
5		(0.9)
6	ACP	<Yeah> (0.7) I'll have a word:.
7		(1.1) ((Pat. brings tissue to mouth))
8	ACP	I'LL ↑HAVE A WORD. ((ACP taps/touches pat. leg))
9		(0.8)
10	Pat	Don't offend th:em.
11		(0.4)
12	ACP	°No £I know£ .hhh hu°
13		(0.9)
14	Pat	[But they'll ha (.) [they'll (hate/hurt)] me.
15	ACP	[I'm <sorry:.> (.) [but you'll]
16		((ACP taps/touches arm))
17		(0.2)
18	ACP	No: okay. (0.4) >Do you want me to have a wor:d.<
19		(2.0) ((Pat. tissue across mouth/?? Pat. sniffs))
20	ACP	Do you want me to have a word.

21 ((ACP brings head closer to pat.))
22 (1.8) ((Pat. crying))
23 ACP tsk Oh (0.9) Oh <sweetheart okay.>
24 (0.6)((ACP moves and puts arm around pat from Oh then
25 strokes arm))
26 Pat ~.hh .hhh (.) .hh~
27 (0.7) ((ACP arm remains around shoulder. Stops stroking))
28 ACP >What can we make (0.3) how can we make< things better.
29 (1.7)
30 Pat ((Sniff – Crying – pat blows nose))
31 (0.5)
32 ACP ↑How can [we make] things <◦better.◦>
33 ((ACP releases hold/leans on chair arm with chin on fist))
34 (0.3)
35 Pat ~#↑Don't ↑throw ↑me.#~
36 (0.3)
37 ACP Don't throw you okay
38 (1.6)
39 Pat ~#It's horrible.#~
40 (0.4)
41 ACP <Alright>=

While the patient's initial talk in line 1 is unclear[32], meaning analysis of that talk and the ACP's response in line 4 is not possible, the end of the patient's turn – "it's the throwing" (line 2) clearly re-introduces the complaint about assistance with movement. The patient also concurrently raises and brings down a clenched fist, perhaps emphasising the extreme case formulation. The ACP aligns with the talk saying "yeah" and then, following a silence, offers a solution - "I'll have a word" (line 6 & 8). In comparison to extract 6.8, where the ACP's intervention, 'asking them to be gentle', focused on future action, 'having a word' potentially suggests that the ACP is going to issue a warning or reprimand about a past event. The action of 'having a word' addresses the complaint, rather than the consequences of 'being thrown', and therefore implies affiliation

[32] It is unclear if the patient is saying that 'the pain is terrible' or introducing the complaint by saying that 'it's not the pain itself that's terrible'. The ACP responds before the patient starts the explicit complaint.

with the patient's complaint. While the ACP does not state what she will have a word about, there is evidence in the patient's response, "don't offend them" (line 10), that she perceives the ACP has explicitly acknowledged the complaint and is going to address it. The patient's instruction also introduces a potential problem – possible negative consequences of addressing the complaint. The ACP's response "no I know" (line 12) aligns and agrees with the patient's stance that addressing the complaint requires delicacy. Following a silence, the patient upgrades her concerns about possible negative consequences - "but they'll ha they'll (hate/hurt) me" (line 14). The ACP aligns, abandoning her turn in line 15 and, receipting the patient's talk with "no okay" (line 18). The ACP subsequently proceeds to offer to speak to staff ("do you want me to have a word", lines 18 & 20). In comparison to the declarative "I'll have a word" (lines 6 & 8), which the patient received as affiliating with the complaint, the offer here to address the complaint is contingent on what the patient wants, with responsibility for the decision passed to the patient. However, the patient does not accept the offer, becoming increasingly distressed when the ACP repeats her offer (line 20), and when the patient starts crying the ACP responds to her distress.

Throughout extracts 6.7 to 6.9, the ACP has aligned as the recipient of a telling, and offered problem solutions that are within the ACP's institutional remit (e.g. pain control, asking staff to be gentle). The ACP has not however, fully affiliated with the patient's complaint. While, as already discussed, there may be good reasons for the ACP not to affiliate with the complaint, when the patient displays distress (crying), the ACP clearly responds to the emotional tone. Initially, the ACP registers the patient's distress and her awareness of this distress with the change-of-state token "oh". The ACP then responds to the patient's distress moving close and placing her left arm around the patient's back, stroking the patient's arm with her right hand, and saying "oh sweetheart okay" (line 23). In previous research, patients and healthcare professionals have described providing comfort as a feature of compassion (Durkin, Jackson and Usher, 2021a; Su *et al.*, 2019; Sundas *et al.*, 2020). There is also evidence in conversation analytic work in children's pre-school settings that shows how carer's embraces, when children cry, display both empathy and the alleviation of suffering/compassion (Cekaite, 2020). Extract 6.9 shows how when the patient displays distress, ACPs appear to prioritise responding to the emotional tone and alleviating the distress rather than other agendas or projects.

Following responding to the patient's distress the ACP gradually progresses the interaction back towards talk (and solutions), first stopping stroking and then asking "how can we make things better". A silence follows where the patient blows her nose, and the ACP removes her arm from around the patient, before repeating the question. Following immediately from the patient's distress, the question "How can we make things better" (line 32) appears to respond directly to the patient's distress, seeking ways to help and reduce her distress. The question also suggests that the ACP is unaware what needs to be done – the solution is outside the ACP's epistemic domain, and potentially within the patient's epistemic domain. The patient responds with the negative formulation "don't throw me" (line 35), which is both a complaint and an instruction. The ACP's repeat "don't throw you okay" (line 37), which Goldberg (1975) shows can acknowledge an instruction, appears to accept the utterance as an instruction and therefore accepts the criticism of staff. By repeating the instruction, the ACP also avoids potentially exacerbating the patient's distress, as occurred earlier when she informed the patient that she would "have a word" (line 8). Repeats can also provide an opportunity for patients to say more (Jenkins, Parry and Pino, 2021) and, following a silence, the patient continues describing her experience of throwing – "it's horrible" (line 39). The ACP aligns receipting the patient's talk with "alright" (line 41) and, as shown in the continuation of extract 6.9 below, the patient continues her complaint.

Extract 6.9b "It's the throwing" (continued)

(CiP15, v.3, L.368) Time 08:15

42	Pat	=~.hhh #It shouldn't (ev[er)#~
43	ACP	[<Gentle.> ((ACP touches pat. leg))
44		(0.7)
45	Pat	[#↑It shouldn't have] to happen#
46	ACP	[◦That's what you <need>◦]
47		(0.6)
48	ACP	<Alright.> (0.5) [<I'm sorry.>]
49	Pat	[( )] ~.hhh hhh #It's [cruel↑ty#~]
50	ACP	[I'll I'll]
51		sort it out ((ACP touches hand))
52	Pat	#<It was cru:elty>#

53 (0.3)
54 ACP [˚I'll sort it out:.]˚
55 Pat [#↑Absolutely] (0.5) absolutely (.) ~cruel~
56 (0.6)
57 ACP <I know:.=I'm [sorry.>
58 Pat [(#they've been#)
59 (0.7)
60 Pat ( )
61 (0.5)
62 ACP O:kay. (0.8) Alright.=
63 Pat ~<I'm sorry.>~
64 (.)
65 ACP >No don't you< apologise:. (0.7) an I think
66 Pat #.hhh hh#
67 ACP We didn't realise you were in <so much pain: from that so
68 now we know ((ACP points when says pain))

While the patient continues to talk throughout extract 6.9b, she remains distressed and continues expanding her complaint. Following "it shouldn't ever" (line 42), which is abandoned when the ACP's talk overlaps, the patient re-commences the turn stating "It shouldn't have to happen" (line 45). While in overlap the ACP has suggested a future action, which focuses on patient need ("gentle" (line 43), "that's what you need" (line 46)), she does not pursue the problem-solution. Instead, the ACP aligns with the patient's claim that throwing 'shouldn't happen' (line 45), initially stating "alright" and then proceeding to apologise "I'm sorry" (line 48). In addition to aligning, the ACP's apology explicitly affiliates with the patient's complaint regarding 'throwing'. As in extract 6.4, the ACP's affiliation appears to result in expansion of the complaint with the patient stating "it's cruelty" (line 49). In overlap, with the patient's assessment that the throwing is cruel, the ACP acknowledges the problem stating that she will "sort it out" (lines 50-51). Following the overlapping talk, the patient repeats her assessment (line 52) and the ACP repeats her declaration ("I'll sort it out", line 54). The patient however, subsequently increases the intensity of her assessment with "absolutely cruel" (line 55) and shows indications of increasing distress. In the next turn, rather than repeating that she will 'sort it', the ACP states "I know.=I'm sorry" (line 57). The ACP therefore explicitly affiliates again with the complaint. Firstly, the ACP appears to show that she understands that the 'throwing' is cruel. Secondly, the ACP

apologises, which in effect accepts responsibility for the complaint. Shortly after the ACP's apology, the patient's distress subsides and the patient does not complain about throwing again for the remainder of the encounter. In comparison to earlier responses to the patient's complaints about 'throwing', where the ACP uses a number of different strategies to avoid explicitly affiliating with the patient's complaint and hence the criticism of staff, in the circumstance when the patient displays distress, the ACP appears to prioritise alleviating the patient's distress. As discussed earlier in this data, not affiliating with patient complaints about fundamental care may enable the provision of long-term care which could prevent further suffering. However, when patients display distress ACPs appear to respond to the emotional tone, and affiliate with the patient's complaint, both of which could be described as compassionate in the interactional moment.

6.5 Discussion

In Chapter 5, the analysis focused on ACP responses to patient problem-tellings. This chapter has focused on ACP responses to patient complaints about ACP actions during the interaction, and complaints about care by third-parties. Again, analysis raises questions about how compassion is conceptualised in nursing, what is involved in compassionate interaction, and the interplay between clinical care, responding to suffering and the prevention of harm.

In the first part of the chapter, extracts exemplified the ACP's responses to patient complaints about a transgression by the ACP during the interaction. As in Chapter 5, ACPs aligned and affiliated with the complaint acknowledging the patient's suffering. However, the practices ACPs used to affiliate differed, both between the complaints and from those discussed in relation to patient problem-tellings (Chapter 5). In extract 6.2, where the patient complains about an embodied action (the ACP's cold hand touching the patient), the ACP responds with an explicit apology. In extract 6.3, where the patient complains that the ACP's talk minimises his experience of pain, the ACP affiliates with the patient's stance using "I know", before correcting her talk. Acknowledging suffering and responding compassionately may therefore involve a variety of practices depending on the context. These practices are more specific than generic features of communication, captured by, for example, the listening and

empathising identified in previous research on compassion in nursing (see Figure 2.2, p.36 and Appendix 7). Additionally, given the relatively minor nature of the transgressions, the ACP responses perhaps provide empirical evidence of 'the small acts' referred to as a component of compassionate nursing practice, in both policy (Department of Health, 2008; Department of Health, 2015) and research (Bramley and Matiti, 2014; Straughair, Clarke and Machin, 2019; Tierney *et al.*, 2016). The findings show however, that these 'small' acts are not one practice, highlighting the importance of starting to distinguish how these 'small' acts occur in interaction. The data also show how important these seemingly 'small' acts are. ACPs acknowledging and affiliating with the patient's complaint that their action has resulted in a minor transgression, which could cause the patient (minor) suffering, may assist in building social cohesion (and trust) (Heritage, 1984b; Lindstrom and Sorjonen, 2013) in the non-familial transitory relationship between ACP and patient.

The second part of the chapter explored patient complaints regarding third parties, including complaints about a staff member at a care home (extract 6.4) and care by other ward staff. Again, analysis of the data suggests that affiliating with the specific complaint and acknowledging the patient's suffering is an important component of patient care, which could be described as compassionate. In extract 6.4, the ACP initially displays general regret that the patient's discharge from hospital was unsuccessful. Only following the patient resuming her complaint and the ACP affiliating with its specifics does the sequence conclude. Similarly, in extracts 6.7 to 6.9 the patient repeatedly raises a complaint about 'throwing', which only concludes when the ACP apologises and affiliates with the complaint. In extracts 6.8 and 6.9, the patient continued to complain about being thrown, after the ACP had offered problem-solutions. However, affiliative practices, sensitive to the specific interactional context, appear to be an important component of responding to both patient complaints and problem-tellings. Patients treat ACP affiliation with their complaint as both necessary and adequate and, as discussed in relation to patient problem-tellings, these practices which acknowledge suffering could be described as compassionate within the interactional context.

While the investigation of both patient problem-tellings and patient complaints show that affiliation is an important response, which acknowledges suffering and

facilitates progressivity, the analysis also shows that ACPs do not always affiliate with patient complaints about third parties. ACPs displayed a number of methods to avoid fully affiliating with criticisms of other staff, including minimal receipts, change of state tokens such as 'oh', and offering future-focused problem-solutions. When ACPs did affiliate with criticisms of other staff, mitigation such as "that happens everywhere" (extract 6.6) and "we didn't realise you were in so much pain" (extract 6.9, line 67) accompanied affiliative responses. These examples raise questions regarding the idea that ACP's can or should always affiliate with patient complaints, in order to offer the understanding compassionate response, which policy suggests is desirable. There may be good institutional reasons for not affiliating with complaints, especially when they are about ongoing care in the current setting. As the existing literature suggests, and as extract 6.4 shows, affiliation can result in a complaint escalating (Drew and Walker, 2009). Ultimately, in extract 6.4 the ACP acknowledges that the delivery of care at another institution was unacceptable. Essentially the ACP strongly affiliates with the patient's stance, displaying understanding and compassion regarding the patient's experience. However, in relation to extract 6.4, field notes confirm that the patient would not return to the complained-about location. Offering an affiliative, compassionate response was therefore unlikely to have any long-term consequences for care relationships. In comparison, displaying affiliation and escalating patient complaints about current care, in an ongoing care setting, could have long-term detrimental consequences. As Ruusuvuori and Lindfors (2009) suggest, affiliation with patient complaints could threaten the credibility of healthcare and professional relationships. For example, fully affiliating with the patient's complaint about 'throwing' in extract 6.7 to 6.9 could potentially result in the patient refusing to be moved. Immobility poses a number of health risks, and focusing on resolving the problem through pain relief, prior to assistance with movement, and asking staff to be gentle may be more effective methods of preventing long-term suffering and negative outcomes. However, such responses may be at the expense of what is perceived as a more compassionate short-term response. As Antaki and Webb (2019) show in relation to interaction between support workers and adults with cognitive impairments, support workers may find themselves in a difficult position where they have to prioritise an overarching project, over the service user's immediate wishes.

The exception to this general principle occurs in response to distress. While ACPs may use strategies to avoid explicitly affiliating with third-party complaints, when a patient displays visible distress, the ACP's response changes and she prioritises the alleviation of immediate distress and suffering. In extract 6.9, the ACP responds to the emotional tone (Pilnick *et al.*, 2021), offering what could be described as comfort. Similar multimodal responses have been shown to facilitate return to the ongoing consultation and progressivity (Merlino, 2021), and compassion in carer-child interaction in nurseries (Cekaite, 2020). In comparison to problem-tellings and complaints about third parties, which predominantly report suffering at another time, distress is a clear demonstration of suffering within the moment. Although a rare occurrence in the data collected, this distress provides a clear opportunity to alleviate rather than acknowledge suffering.

Chapter 7 Analysis: ACP other-initiated repair

7.1 Introduction

Previous chapters focus on ACP responses to patient's problems-tellings and complaints. ACP practices that could be described as compassionate were shown. Questions were also raised about whether these practices were always possible. In some contexts over-arching care needs, such as being assisted to move, appeared to override practices which could be described as compassionate. In the final analysis chapter, ACP responses to patient-talk are again the focus of analysis. However, while in previous chapters analysis started from patient actions that potentially display suffering, this final chapter focuses on an ACP action that could potentially cause suffering:- ACP other-initiated repair of the patient's talk. Other-initiated repair occurs when an interactional trouble arises, such as difficulty hearing or understanding talk, and the recipient alerts the speaker to this trouble and a loss of intersubjectivity (Schegloff, 2007). While other-initiated repair may be necessary in contexts where ensuring a shared understanding is imperative for effective care, other-initiated repair potentially threatens the 'face' of participants (Robinson, 2006b). It could therefore be argued that, in some contexts, this 'face-threat' could cause or exacerbate suffering[33].

Following briefly outlining other-initiated repair in the data-set, this chapter will focus firstly on ACP open-class repair initiators, which occur predominantly when the ACP is engaged in a concurrent activity, such as a procedure or examination. Secondly, the chapter will investigate alternative repair initiation practices, exploring how and where they occur, and patient responses. The chapter will again outline practices which could be described as compassionate, and also further explore the complexities involved in managing the competing demands

[33] While the suffering caused by face-threats may be relatively minor, and not suffering in a 'grand' sense, the literature review suggested that compassion comprises relatively 'small things', therefore investigation of such features of talk is relevant.

of ensuring long-term safe and effective care, and compassionate responses within the immediate interactional context. Before this, I will briefly outline what repair is, and summarise previous conversation analytic work on other-initiated repair in health and social care settings, in order to contextualise findings.

7.2 Background

7.2.1 Repair

Repairing talk is recognised as fundamental to orderly talk-in-interaction (Schegloff, 2007). Without participants being able to initiate repair, breakdowns in intersubjectivity could result in both interactional chaos, with people speaking over each other, and functional chaos, with people not knowing, for example, if they are providing the required information. Repair allows the restoration of intersubjectivity, progressivity and the completion of actions (Schegloff, 2007). As such, repair possesses its own structural features, which allow participants to:

"interrupt the ongoing course of action to attend to trouble in speaking, hearing or understanding the talk" (Kitzinger, 2013, p.229).

When these troubles-in-talk occur the interaction-in-progress essentially stalls, and a new (side) sequence with its own structural organisation follows. This repair structure is built around the trouble source – the problem with a word, sentence or turn. Repair therefore depends on a participant identifying a trouble source, and deciding that repair is necessary for the ongoing smooth progress of the action. As Jefferson (2017) shows, repair may be recognised but passed over i.e. not initiated by the recipient of a trouble source turn.

When a trouble source is addressed by a participant, repair is organised into a sequence including initiation, solution and abandonment (Schegloff, 1997), with either the trouble source speaker or the recipient performing initiation and/or resolution. A trouble source speaker may self-repair a trouble by, for example, replacing a word (e.g. 'about a month uh (.) abou- no about two weeks before' (Kitzinger, 2013)). The recipient of a trouble source may also initiate repair (other-initiated repair), for example, by using 'huh?' or 'sorry?' Self-repair does however, occur more frequently than other-initiated repair in everyday

interaction (Schegloff, Jefferson and Sacks, 1977). Based on the different frequencies of self- and other-initiated repair, Schegloff et al (1977) proceeded to show how the organisation of repair resulted in a preference for self-repair. Recipients of a trouble source tend to withhold their repair initiation until the speaker has completed their turn, or a little after, as is often shown by the longer than usual gap prior to the recipient's repair initiation. The speaker of the trouble-source therefore has the opportunity to self-repair during and immediately following their turn. Self-repair is therefore the preferred mechanism for repair, often restoring progressivity within the same turn (as in the example of replacement above) and avoiding the recipient from having to expose a breach in intersubjective understanding. Through self-repair the speaker essentially saves 'face' and avoids the recipient having to draw attention to the inadequacy, for purpose, of the speaker's talk. As Robinson (2006b) states, other-initiated repair raises the possibility that the trouble-source speaker has bypassed the opportunity for self-repair, implying that they are responsible for the trouble and therefore questioning their competence and positive 'face'.

As self-repair is preferred, an other-initiated repair sequence generally follows the speaker's turn that involves the trouble source, presenting as an insert expansion or a post expansion[34]. Other-initiated repair in the next turn also assists the trouble source-speaker in identifying the trouble; however, other-initiated repair may be delayed when, for example, an ongoing telling is in-progress or to register receipt of a response (Schegloff, 2000)[35]. The form of repair-initiator used by the recipient will also vary, in the extent that they locate the trouble-source and allow the trouble-source speaker to provide the repair solution. The most commonly described forms of other-initiated repair listed by Kitzinger (2013) are:

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[34] Insert expansions occur within adjacency pairs, e.g. between a question and answer. In comparison, post-expansions occur in the turn following an adjacency pair, e.g. following the answer to a question (Schegloff, 2007).

[35] While the norm is for other-initiated repair to occur in the turn after the trouble-source, misunderstandings can evolve over a number of turns (Wong, 2000).

1. Open class repair initiators such as 'sorry? or 'huh?', which imply that the other is aware something was said, but not what was said.
2. Category specific repair initiators, which include 'wh' questions (e.g. who, when and where) and locate the trouble as related to the referent.
3. Partial or complete repeats of the speaker's talk, which claim capacity to have heard (all/part of the talk) and to repeat the talk, but not to understand the meaning of the utterance.
4. Candidate understandings such as 'you mean a ..' or 'like a …', which identify the trouble source and check that the recipient has understood what was being said.

As Schegloff et al (1977) claim, the list is not exhaustive and other forms of other-initiated repair have been proposed. Koshik (2005), for example, discusses alternative questions as a form of other-initiated repair. They are however, potentially similar to repeats and candidate understandings – locating the trouble source word and then offering a candidate answer. In everyday talk, while recipients of a trouble-source turn may initiate repair, they rarely offer the solution or explicitly correct another's talk[36]. Even when a candidate understanding is offered, this is often presented as a proposal, for acceptance or rejection by the trouble-source speaker (Schegloff, Jefferson and Sacks, 1977).

With regards to the various forms of other-initiated repair listed above, no exact relationship has been identified between the repair-initiator used and the trouble-source (Schegloff, 1987b; Drew, 1997). While an open-class repair initiator may be the only option if no part of a turn is heard, a partial repeat such as 'Ross what?' (Svennevig, 2008) may indicate partial hearing or partial understanding. Additionally, while an open-class repair initiator may display and be received as an issue with hearing, since we are unable to see into the minds

[36] Correction by the recipient of a trouble-source turn is rare in everyday interaction between adults (Schegloff et al, 1977). Not only does correction pose a 'face' threat, displaying that the speaker's turn was somehow deficient (Svennevig, 2008), if a recipient can correct a speaker's turn they show that the talk was adequate and that they could produce the appropriate next turn. Schegloff (1977) therefore claims that in everyday talk correction displays disagreement.

of others, we cannot be categorically sure this means that the recipient did not actually hear (Drew, 1997). Other-initiated repair can perform a number of other actions including surprise (Wilkinson and Kitzinger, 2006) and indicating an upcoming disagreement (Schegloff, 1997). The latter allows the trouble-source speaker the opportunity to amend their talk and avoid a possible dispreferred response (Schegloff, 2007). Svennevig (2008), for example, shows how certain repair practices can be used by participants to display problems of acceptability regarding the truth claims made by a speaker, the speaker's right to perform the action and/or the relevance of the talk. If the actions of repair include more than addressing troubles with hearing and understanding, as Schegloff et al (1977) claim, then repair can potentially occur anywhere within interaction.

While there is no exact relationship between the source of a trouble (hearing or understanding) and the type of repair-initiator used by a recipient, there is some evidence that 'face' considerations are involved in the format of other-initiated repair. As previously discussed, Goffman (1955) adopted the term 'face' to describe the positive social value participants give and receive during social interaction. Positive 'face' is not lodged in the individual but maintained and constructed within interaction. Where a participant's actions threaten the 'face' of other participants, producing potential embarrassment or conflict (Goffman, 1955), the speaker could be said to be causing suffering. Maintaining the 'face' of others could therefore be regarded as a compassionate act. While other-initiated repair may be necessary for the restoration of intersubjectivity and progressivity, other-initiated repair is one location in talk where positive 'face' may be threatened (Robinson, 2006b; Svennevig, 2008). There is however, some evidence that certain forms of other-initiated repair, may be less face-threatening than others. Robinson (2006b) showed how apology-based formats of other-initiated repair such as 'sorry' implicated the recipient as responsible for the loss of intersubjectivity, and therefore did work to avoid threatening the 'face' of the trouble-source speaker. In addition to other-initiated repair formats, which avoid attributing responsibility to the trouble-source speaker, there are also suggestions that a preference exists for repair initiators, which display a lack of hearing e.g. open-class repair initiators, regardless of whether the recipient has heard the talk. Sacks (1995) claims that admitting a failure to understand may display a lack of competency, and therefore may be done less willingly than displaying a lack of hearing. Svennevig (2008) supports Sacks'

(1995) claim that, when a sequence of multiple repairs are initiated, repairs that focus on issues of hearing are usually displayed before repair-formats that address issues of understanding or acceptability. The preference for repair-formats which focus on issues of hearing, rather than understanding or acceptability is common-sense – a recipient cannot know what they have and have not understood if they have not heard. However, there are suggestions that repair initiators, which imply a problem with hearing may be preferred due to the work they do to avoid face-threats (Svennevig, 2008), regardless of whether the recipient has actually heard adequately.

7.2.2 Other-initiated repair in institutional settings

The extent and acceptability of other-initiated repair will of course depend on the context. In some institutions other-initiated repair, and other-repair or correction, which is regarded as highly face-threatening in everyday talk (Svennevig, 2008), may be an accepted means of achieving institutional goals. In education, for example, correcting grammar or pronunciation can be a means of facilitating learning (Hall, 2007). In relation to the healthcare context, although there is limited evidence, there are reasons to believe that other-initiated repair, especially if it encompasses correction, would be a dispreferred action because it potentially exposes issues of competence. Certainly, there are suggestions that correcting the talk of someone with dementia, could be interpreted as questioning the other's competence in managing their own talk (Webb, Lindholm and Williams, 2020). As such the correction could be described as uncompassionate, threatening the 'face' of the person living with dementia. However, there have been suggestions that in atypical interaction, some forms of other-initiated repair may be a supportive strategy. Referring to candidate understandings in Wilkinson et al's (2010) work on talk with people with aphasia, Antaki (2012) shows how candidate understandings, which provide new information and progress talk may be an affiliative action. Similarly, in relation to talk between family members' and a person living with dementia, Lindley (2016)[37] shows that other-initiated repair, performed in a manner which

[37] Lindley's (2016) data occurs within the context of an existing relationship – between the person living with dementia and a family member. This contrasts

lowers the risk of exposing issues of competence or avoids placing responsibility for the trouble with the person living with dementia, can manage the interaction and treat the person as a fully competent participant.

7.2.3 Alternatives to other-initiated repair

The above research on other-initiated repair suggests that the action and its relationship to compassionate healthcare will be potentially complicated, and dependent on the context. In certain situations ACP other-initiated repair may be supportive, progressing talk and facilitating intersubjectivity. In such locations, other-initiated repair could potentially be compassionate. In other situations other-initiated repair may expose issues with competency and present a potential uncompassionate face-threat. Other-initiated repair is not however inevitable and there may be alternatives. As Schegloff et al (1977) note, while a repairable may be identified by participants, not all repair opportunities will be acted upon. Subsequently, Jefferson (2017) explored the identification of non-correction (or passing over of an error), suggesting that what is, and is not, repaired is socially organised. In relation to healthcare settings, Pilnick et al (2021) suggest that healthcare professionals may use minimal response tokens, repetition, responding to the emotional tone or closing of a topic as a means to avoid repair initiation, when the talk of a patient living with dementia is hard to interpret. As the work by Pilnick et al (2021) suggests, there may be occasions in healthcare when passing over a trouble source, and avoiding a potentially face-threatening repair initiation, is unlikely to impact on clinical care. However, there will also be occasions in healthcare when other-initiated repair is necessary, for a precise understanding of symptoms or medication, for example. In such scenarios other-initiated repair may be necessary for safe and effective care.

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with Webb, Lindholm and Williams' (2020) data which occurs in the context of talk between people living with dementia and staff at a day centre.

7.3 Overview of other-initiated repair in ACP-patient interaction

Other-initiated repair of patient talk occurred in twenty of the twenty-seven consultations recorded. Consultations where there was no ACP other-initiated repair were generally shorter, and were in the context of patients approaching discharge. In comparison, ACP other-initiated repair seemed to appear more frequently in consultations where there was more problem-talk, different patient–ACP agendas, and where a patient may have atypical communication. Within these consultations, other-initiated repair occurred predominantly during history-taking, when the ACP was seeking relevant medical information. During these times ACPs used open-class repair initiators, category specific repair initiators, repeats and candidate understandings in order to initiate repair. First, I will however, discuss the use of open-class repair initiators, which occurred predominantly when the ACP was engaged in a procedure or examination.

7.4 Open-class repair initiators during physical examinations and procedures

Open-class repair initiators such as 'sorry', 'pardon' and 'hm' are frequently associated with issues of hearing (Svennevig, 2008), and in the current data set patients attributed the open-class repair initiators used by ACPs to issues of hearing. There was also evidence that ACP open-class repair initiators occurred predominantly during multi-activity, when the ACP was concurrently performing another task, such as preparing for a procedure. Extract 7.1 exemplifies both an ACP other-initiated repair which occurs during multi-activity, and the receipt of the repair initiator as a problem with hearing. The extract is from an eighteen–minute consultation between ACP Sarah and Pearl, a ninety-two year old with dementia, who was admitted with a chest infection. Pearl's daughter was also present during the consultation. The open-class repair initiator occurs six minutes and fifteen seconds into the consultation, as the ACP is preparing to cannulate the patient. In the talk prior to the ACP's open-class other-initiated repair (line 17), the companion has told the patient what the ACP is going to do (line 3) and following the patient initiating repair (line 5), the ACP provides an explanation about what she is doing.

Extract 7.1 "Have you got a bucket"

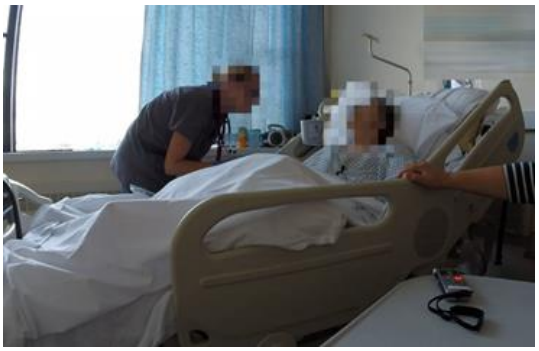
(CiP16 v.2 L.281) Time: 06:15

1	Pat		What () ((Pat slight movement towards com))
2			(0.2)
3	Com		They’re going to look for a <vein>
4			(0.2)
5	Pat		Heh?
6			(0.3)
7	ACP		I’m just going to pop this <down here> (0.7) and then I’m
8			just going to <clean> the area. I might just (.) bring this
9			up a little bit actually
10			((Com reaches for pts hand taking at ‘bring’))
11			((ACP looks up towards com. at ‘bring’ before looking back
12			down & cleaning pts arm))
13			(1.0)
14	Pat		Have you got your bucket here ()
15			((Pat turns slightly away from ACP))
16			(0.5)
17	ACP	→	↑Sorry?
18			((ACP continues with task))
19	Pat		Has she brought her bucket with her.
20			(0.6)
21	Com		A [bucket?]
22	Pat		[(She’s)]
23			((Pat looking towards ACP/ACP lifts head up looks at pat.))
24			(.)
25	Pat		Yeh.
26			(0.2)
27	ACP		[<↑Wh:y?>]
28	Com		[To catch the] blood
29	ACP		£Oh£ [.hh he he ha ha ha:.hhh h £Oh go:sh£ hu h

The open-class repair-initiator "sorry" (line 17) occurs following the patient introducing a new topic about the ACP having brought a bucket[38] (line 14). While the patient's talk is difficult to hear, the video-data in image 7.1 also shows that the ACP is involved in preparation for the cannulation.

Image 7.1 "Have you got your bucket"

Pat. Have you got your bucket here



ACP starts to look up as patient's daughter says "a bucket?" (line21)

Apart from briefly looking at the companion (line 8), the ACP's head is down and her focus is on preparation for cannulation. The ACP's talk in lines 7-9 is also hearable as an online explanation (Heritage and Stivers, 1999; Heritage *et al.*, 2010) about what she is doing – a response is not necessarily expected or required. The patient's topic initiation "have you got your bucket here" (line 14) therefore occurs when a joint focus of attention is absent and results in interactional trouble. The ACP responds with the open-class repair initiator

[38] While the patient's question "have you brought your bucket" could be responding to the ACP's talk that they are "just going to clean the area" (line 8), it is hard-to-interpret and potentially introduces a new topic.

"sorry" (line 17), an insert expansion, which shows that she is unable to provide the appropriate response. The patient's repair solution "has she got her bucket with her" (line 19) is largely a repeat of her original talk in line 14, framing the problem as an issue with hearing (Robinson, 2006b). The patient therefore attributes interactional trouble to the listener (the ACP) rather than her talk. While the patient's repair solution is a repeat, there are subtle changes in the construction of the turn. In the trouble-source turn the patient referred to "you", while in the repair-solution the patient directs the repair solution to the companion, referring to "she" and "her" (line 19). By shifting who the repair is directed towards, the patient reinforces that the trouble relates to listenership and perhaps shows recognition that the ACP has another main focus of involvement, which reduces her ability to maintain a joint focus of attention.

Similar features are evident in extract 7.2, which occurs one minute forty-five seconds into a twenty-two minute audio-recorded consultation between ACP Eve and Anne. The ninety-two year old patient had been admitted to hospital following a fall, and was receiving intravenous antibiotics for cellulitis. During the consultation the ACP re-cannulates the patient, and completes an assessment because the patient was reporting nausea and vomiting. Prior to the ACP's repair initiation, talk has been about the difficulties that the patient is having sleeping and the ACP has suggested earplugs (line 1). The trouble source occurs in line 13 and the ACP responds with the open-class repair initiator – hm?

Extract 7.2 "I need earphones"

(CiP17 v.2 L.36) Time 01:55

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 1  ACP    We can ge:t (0.5) They've got <e:ar: plugs> on the ward (.)
 2         if that ↑helps:.=
 3  Pat    =↑I've (0.2) <tried> em duck but the don'[t wo:rk.
 4  ACP                                             [didn't work.
 5         (0.5)
 6  ACP    They [don't have ]
 7  Pat          [>They won't] even< they won't even <↑stay in.>
 8         (0.5)
 9  ACP    ↑Do they no:t.
10         (3.0)                    ((Tape being ripped))
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11 ACP ◦◦O:kay.◦◦ (0.5) >◦Let me have a look at< this arm again◦
12 (0.3)
13 Pat I need ear↑phones: or something.
14 (0.3)
15 ACP ↑Hm::? (2.4) ↑What ↑was that.
16 (0.9)
17 Pat <↑I need earphones>
18 ACP <↓Earphones> (0.9) ↑Is there anything anybody can bring you
19 in from <ho:me.>
20 (.)
21 Pat U:hm:
22 (0.3)
23 ACP Do you think there is anything that <your family> could
24 bring in.
25 (2.9)
26 Pat ◦I don't know◦

In extract 7.2, as in extract 7.1, there is evidence that the ACP is concurrently involved in another task when the interactional trouble occurs. Prior to the extract, the ACP has requested permission to re-cannulate the patient, and during the three-second pause at line 10, the ripping of tape can be heard.[39] Finally, in line 11 the ACP says, "Let me have a look at this arm again", suggesting that when the patient states, "I need earphones or something" (line 13), the ACP is engaged in preparation for the procedure. As a result, there is unlikely to be a joint focus of attention. However, in comparison to extract 7.1, where the trouble-source occurs when the patient responds to the ACP's online commentary, in extract 7.2 the patient resumes the topic about how they can reduce the noise she experiences at night. Discussion about using earplugs (lines 1-9) closed following the ACP acknowledging the difficulties the patient had experienced with earplugs (line 9). The patient's "I need earphones" (line 13) and the ACP's subsequent open-class repair initiator "hm" (line 15) therefore occur in response to a sequential ambiguity, which results from

[39] Tape to secure a cannula is usually prepared prior to cannulation, and preparation for such procedures often involves looking at the equipment and site.

participants' different focuses of attention. While there is a silence (2.4 secs) and a second subsequent open-class repair-initiation – "what was that" (line 15), the patient's repair solution shows that the repair is received as an issue with hearing. The patient's repeat "I need earphones" (line 17) is said slowly with each word precisely articulated.

In both extract 7.1 and 7.2, the ACP repair-initiators occur at a location in the interaction where there is a potential conflict about the main focus of attention. As Drew (1997) has previously shown, open-class repair-initiators can occur at topical disjunctures, where an unanticipated topic shift occurs from the perspective of the recipient, but the trouble source speaker regards their talk as an appropriate next turn. In this ACP-patient data, open-class, other-initiated repairs occur at a point where there is a sequential ambiguity about what is currently occurring in the interaction. While the patient's talk cannot be fitted to the ongoing action for the ACP, the ambiguity appears to be related to the multiple activities that are occurring during the interaction. In extract 7.2, while the patient has resumed the previous topic of talk, the ACP has indicated that she is involved in a clinical procedure. Since at this point the procedure does not require active patient participation, the patient is in a position to continue the previous talk about her lack of sleep. Similarly, in extract 7.1 the ACP is also indicating that she is involved in preparing for a procedure. The patient is not however, directly involved in the preparations, so talk continues to be the primary focus of the interaction for her.

The open-class repair initiators in extracts 7.1 and 7.2 may appear to be the antithesis of the compassion described in policy and previous research. In both policy (Department of Health, 2008) and previous research (Figure 2.2), attending and listening are identified as key components of compassion. However, the open-class repair initiators (extracts 7.1 and 7.2) show that a joint focus of attention is lacking, and the ACP's inability to listen and attend to the patient's talk. The open-class repair initiators therefore potentially threaten the ACP's 'face' as a compassionate practitioner. However, when the open-class repair initiator occurs, the ACP is focused on another activity – cannulation. Procedures such as cannulation require skill and concentration, to be performed safely, accurately, and with minimal discomfort (Carr *et al.*, 2019). The ACPs appear to prioritise preventing physical suffering, both in the short- and long-

term, over attending and listening to patient talk. As in previous chapters, the competing demands occurring during ACP-patient interaction, suggest that the relationship between clinical care and the interactional features of compassion, described in policy and research, are not always straightforward in a context where ACPs regularly have to multi-task.

Having shown that maintaining a joint focus of attention may be difficult, at times when the ACP's main concern is preparing for procedures and examinations, the question becomes how do ACPs overcome potentially displaying their lack of attention? One possibility may be for the ACP to prevent the need for the open-class repair initiator by, for example, explicitly announcing their limited ability to participate in the talk. Such an announcement may inhibit patient talk during a procedure. However, an announcement does not resolve the interactional trouble or face-threat that may occur, when patient talk occurs during a procedure, and the ACP is unable to respond due to a lack of attention. To ignore the talk would be a breach of the turn-taking system and an accountable action (Sacks, Schegloff and Jefferson, 1974). In the context of performing healthcare procedures or examinations, to ignore the turn would also reject the patient as a co-participant in the interaction, and potentially objectify them - treating the patient as something to be done to, rather than talked to. Ignoring patient talk during procedures would therefore be extremely face-threatening. The ACP therefore needs to respond, but if they cannot respond with the appropriate next turn, they have limited options available. One option identified in the data were open-class repair initiators. That ACPs oriented to the open-class repair initiator as a potentially face-threatening act, which potentially exposed their lack of engagement or interest in the patient's talk, is shown in the subsequent talk in the extracts presented here. As extract 7.2 shows, following the repair solution, the ACP pursues the topic resumed by the patient. Following receipting the repair solution offered by the patient, with the repeat "earphones" (line 18), the ACP pursues the topic asking, "Is there anything anybody can bring you in from home." (lines 18-19). After a repair sequence initiated by the patient (lines 21-23), the patient responds with "I don't know" (line 26). While the patient's answer is ambivalent, the post-repair sequence shows that joint attention is focused on the patient's talk about difficulty sleeping. The decision to pursue talk once intersubjectivity is restored may be based on clinical relevance and, in extract 7.2, getting something to block out noise may help the patient sleep and

aid recovery. However, the regularity in this dataset with which the ACP pursues the topic that was part of the repair sequence, suggests that displaying attentiveness immediately following a repair sequence may be a means of restoring 'face'.

Extract 7.3 provides further evidence that by pursuing the patient's topic of talk introduced in the trouble-turn, following other-initiated repair, ACPs show continued attentiveness. The repair sequence occurs nine minutes into a fourteen-minute consultation, and ACP Eve is preparing to examine Jenny, a sixty-eight year old patient with respiratory illness. As the interaction is being recorded, the ACP informs the patient that she is going to cover the patient with a pillow, in order to maintain her dignity, during an abdominal examination.

Extract 7.3 "So I'm not commando"

(CiP23, v.2, L.333) Time: 09:06

1	ACP	((Removes stethoscope from around neck and takes a pillow
2		from the bed))
3		Uh↑m hm. (0.4) I'm gunna pop this <he:re> just in case I
4		(1.2) I flash anything. (0.2) There we go.=>↑You hold that<
5		pillow for me.=[And I'll just ↑stick my]
6		((ACP putting pillow under patient's nightdress. Puts
7		stethoscope to ears))
8	Pat	[◦(Cos) I'm (a) <comman:]do:>◦
9		(0.3)
10	ACP	↑H:m:
11		(0.5)
12	Pat	◦<↑So I'm not ↑COmman:do:.>◦
13	ACP	◦Hh >That's ↑o:kay that's ↑why I'm ↑cover↓ing you,< hu h:he
14		[hu he h hu hu h hu ha he
15	Pat	[<Ye:ah::> hu hu eh hu huh ha her
16	ACP	.Hhh £I'll just pop my stethoscope here. (0.2) and then I
17		won't see (a)thing£ hu huh he:

The ACP's repair initiation in extract 7.3 occurs during preparation for an examination, where there is again a possible absence of a joint focus of shared attention. Following the ACP stating that she is going to ensure that the patient is not exposed (lines 3-4), there are a number of instructions - "There we go. You just hold that pillow for me. And I'll just stick my" (lines 4-5). The speed and lack of space between the ACP's instructions leave little opportunity for the patient to respond and are similar to the online explanation (Heritage and Stivers, 1999; Heritage *et al.*, 2010) described in extract 7.1 (lines 7-9). During the talk in lines 1-4, the ACP has also covered the patient with a pillow, and when the interactional trouble occurs, the ACP is concurrently moving her stethoscope towards her ears. In overlap with the ACP's "and I'll just stick my" the patient, in a hushed voice says, "(cos) I'm (a) commando" (line 8)[40]. The ACP responds with the open-class repair initiator "hm?" (line 9) and the patient provides the repair solution – "so I'm not a commando" (line 12). The patient's repair in line 12 is a near repeat of her trouble source turn, and displays that she has treated the ACP's other-initiated repair as an issue with hearing.

Evidence that intersubjectivity and progressivity are restored, following the patient's repair solution ("so I'm not commando, line 12), is confirmed when, in the next turn, the ACP responds "that's okay that's why I'm covering you" (line 13). The ACP's turn also expands and progresses the patient's talk (as opposed to the ACP's agenda of completing the examination). Rather than responding to the patient's repair solution "so I'm not commando" with agreement, closure and the next instruction, the ACP responds to a number of features in the patient's talk. Firstly, the patient's evaluation is responded to as a joke. The ACP's response, "that's okay that's why I'm covering you" (line 13), is said with a smiley voice, and is both preceded and followed by laughter particles. Secondly, the ACP's response shows that the patient's repair solution, about being 'commando', displays a certain delicacy. The patient's talk about being 'commando' (lines 8 & 12) was hushed and the ACP's turn continues with whispered talk in line 13, aligning with the delicacy of the situation. Thirdly, the ACP directly responds to any difficulty the patient may have raised about performing the examination, stating "that's okay" and then providing the

[40] 'To go commando' a slang term meaning not wearing underwear (Oxford English Dictionary, 2000)

justification "that's why I'm covering you." The patient's response, an extended "yeah" and laughter particles (line 15), shows that both the humour and the ACP's justification are accepted. While any response is based on the previous turn, by pursuing patient talk following the ACP exposing her own inattentiveness, the ACP displays subsequent attentiveness. This attentiveness orients to the implications of her apparent inattention to the talk. By returning to the topic of talk, the ACP demonstrates that this lack of attention was a temporary rather than ongoing state, and she does work to restore 'face' in terms of the patient as an active participant in the consultation.

7.5 Other-initiated repair during clinical assessment

As the previous section has shown, single word open-class repair initiators were predominantly used by ACPs when they were concurrently involved in another task, and the ACP and patient had different focuses of attention. In comparison, other forms of repair initiation used by the ACP, such as category specific repair initiators, repeat and candidate understandings were commonly found during the history-taking phase of the consultation. Repair initiators could occur as a post-expansion, following the patient telling a story or answering a question, or as an insert expansion following a patient asking a question[34]. As will be shown in the following data, ACP other-initiated repairs were sometimes necessary for fulfilling the clinical agenda of appropriately assessing and treating the patient. However, the consequences of ACP other-initiated repair varied. I will firstly, present data where the other-initiated repair results in resolution, without any apparent threat to 'face'. Secondly, I will present data where the other-initiated repair creates potential face-threats. Here I will show the work ACP and patient undertake to restore the 'face' of participants.

7.5.1 ACP other-initiated repair that supports patient information-giving

Within ACP-patient data there were episodes, as shown in extract 7.4, where resolution of ACP other-initiated repair occurred quickly, and a threat to 'face' was not evident in the data. Extract 7.4 is from a ten minute consultation between ACP Rich and Lillian, a seventy-six year old with breathlessness,

admitted five days before the recording. The extract occurs three minutes into the consultation, as the ACP commences examining the patient's feet. The trouble source is the name of an emollient.

Extract 7.4 "E forty-five"

(CiP10, V.2, L.118) Time 03:07

```
ACP   Can I just have a quick look at your <fe:et>
      ((ACP moves blanket and looks down))
      (.)
Pat   Yeh A >what I wanted to say< (but) .hh they told me to use
      erm:.hh er (0.3) phh.
      ((Pat looks up (to table) & moves fingers on r. hand))
      ((ACP looks up towards pat.))
ACP   E forty <five:.>
Pat   No it's something on [there]
ACP                       [ Cetr]aban.
      ((Pat points to table))
      ((ACP turns to look at the table))
      (0.3)
Pat   Yeah,
ACP   >Yep<
      ((Pat & ACP look down (towards pat's feet))
      (0.2)
Pat   And it's blistered.
      (0.7)                    ((ACP looks up towards pat.))
ACP   Since you star[ted it   ]
Pat                [See there] look there's a blister [come up
ACP                                                   [Yeah
      (.)
ACP   Fine <stop using it then.>
```

Following the ACP requesting to examine the patient's feet (line 1), the patient commences telling the ACP about a product she was told to use (line 4-5). There is however, evidence that the patient has difficulty explaining what this product is. She engages in self-repair, hesitancy ("erm" and "er", line 4-5), and embodied actions such as looking towards the table and moving her fingers.

The ACP proceeds to offer a candidate answer "E forty-five" [an emollient product] (line 8). The patient responds with "no it's something on there" (line 9) and, in overlap, the ACP suggests another emollient product-"Cetraban" (line 10). The patient confirms this with "yeah" in line 14 and then proceeds with her telling, explaining that the emollient has made her skin blister.

As discussed at the outset of this chapter, self-repair is the preferred form of interactional repair (Schegloff, Jefferson and Sacks, 1977), with other-initiated repair potentially drawing attention to the insufficiencies of the trouble-source speaker (Robinson, 2006b). While the ACP's other-initiated repair, in extract 7.4, draws attention to the patient's inability to articulate the emollient's name, the repair displays features that suggest the action may be supportive. Firstly, the ACP's repair initiator shows that the 'gist' of the patient's turn has been understood i.e. that the patient is talking about an emollient. Secondly, the patient is having difficulties articulating her telling, having issued two hesitation markers and a number of breaths (line 4-5). In people with aphasia, Antaki (2012) cites an example from Wilkinson (2010) to suggest that candidate answers can provide new information, which helps meet a need in the speaker's utterance. The hesitation in the patient's talk may indicate that additional medical information is required from her co-participant to progress the telling. The ACP's repair initiator adds medical information, the name of the emollient, which ultimately allows the patient to continue her telling and the ACP to resolve the patient's medical concern. Following an initial rejection by the patient of the ACP's first candidate answer "E forty-five" (line 8), the second "Cetraban" (line 10) is accepted and the patient continues her telling. Ultimately, this telling results in medical advice from the ACP to stop the emollients use (line 24). As Antaki (2012) suggests, other-initiated repair employing candidate understandings, which are designed to add new information, solve a problem and facilitate progressivity may be affiliative. In addition, from the patient's perspective, knowledge regarding the name of a medication could be seen to belong within the epistemic domain of the ACP. In comparison to the naming of symptoms or feelings, which the patient has epistemic primacy over, offering the name of a recently prescribed emollient may pose less of a threat to the patient's epistemic rights. Certainly, in extract 7.4 no apparent work is done to address a 'face-threat' and intersubjectivity is quickly restored.

7.5.2 ACP other-initiated repair during patient talk about previous investigations

In data where patients indicated assistance was required naming something medical, ACP candidate understandings were received as supportive, restoring intersubjectivity and progressivity. As will be shown in extracts 7.5 and 7.6, in other cases of ACP repair initiation, when obtaining a clinical history from the patient, potential face-threats were evident. Extract 7.5 occurs eight minutes fifty-two seconds into a twelve-minute audio-recorded consultation between ACP Sarah and Elizabeth, a seventy-eight year old admitted to hospital following collapsing six days before the consultation. The patient has been experiencing nausea and vomiting and the ACP raises the topic of the findings from investigations exploring abnormal liver function tests (lines 1-7). Nausea and vomiting can be associated with liver problems such as gallstones, therefore ascertaining what investigations the patient has previously had in the community is highly relevant to diagnosis and treatment.

Extract 7.5 "X-ray"

(CiP19, v.2, L.317) Time: 08:52

1	ACP	Cos some of your <liver> function tests were a <bit::>
2		(0.4)
3	Pat	Oh [yes
4	ACP	[<rai:sed.>=
5	Pat	=↑Doc:tors (0.4) picked >that up< as ↑well.
6	ACP	Long ti:me hasn't it,=↑Have they come to the bottom of
7		↑that.
8		(0.6)
9	Pat	I: we:nt in for ↑some↑thing.
10		(0.6)
11	ACP	( )
12		(2.7)
13	ACP	◦O↑kay◦
14		(1.7)
15	Pat	↑Yeh I went in for a liv:er, (1.7) >↑oh no< (.) ↑is it a
16		scan I had ac:ross ↓here.
17		(0.4)
18	ACP	↑In Talkingtown.

```
19          (0.2)
20  Pat     No:. (0.2) At my ↑doc:tors.
21          (1.5)
22  Pat     Cos they've got x-ray:. (0.7) Is t[hat
23  ACP  →                                    [<X-ray,>
24  Pt      Yeah
25          (0.3)
26  ACP     Or an ↑ultrasound.
27          (0.8)
28  Pat     (Hu)
29  ACP     He ha ha £↑am I asking the wrong questions£ (0.8) Okay.
30          (0.2) ↑Do ↑GPs ↑have ↑ultrasound.=I don't know.
31          (0.2)
32  Pat     ↑I don't ↑kn:ow. (0.4) ↑But I know I went (0.7) ↑into Wood
33          Bardale.
34          (0.2)
35  ACP     M:m
36          (0.7)
37  Pat     Because something was showing up on my liver (0.9) an (0.7)
38          I went into where the x-ray department is
39  ACP     Tsk Okay:.=
40  Pat     =An (0.5) he went across ↑e:re.
41          (0.9)
42  ACP     O:kay:.
43          (0.2)
44  Pat     And then >he told me< ↑I was full of ↑st:ones.
45          (0.7)
46  ACP     Yeah, so that came up [on your  ]
47  Pat                           [.hhhh huh] hu huh u [hu  hu  ha:
48  ACP                                               [<Yeah.> That did
49          come up on an old [<CT:> ↑scan
```

There is evidence throughout extract 7.5 that the patient has difficulty providing specific information regarding the investigation performed. In line 9, the patient displays uncertainty about the exact investigations undertaken, reporting that she had "something", while in line 15 the patient cuts off "I went for a liver", exposes her error with "oh no" and then proceeds to self-repair, asking "is it a scan I had across here". Subsequently, prior to dropping out of the overlapping

talk at line 22, the patient says "is that". This turn suggests that the patient is commencing a question, possibly 'is that right?' or 'is that what I had?', which again pursues clarification from the ACP about the investigation performed. In extract 7.5 there is however, also evidence that the ACP does not have direct access to, or knowledge of, the patient investigations previously performed. Rather than answer the patient's question about whether she had a scan (line 15-16), the ACP asks a follow-up question about the town where the investigation was performed (line 18). While the patient completes the question-answer sequence with a disaffirming "no" (line 20) and a clarification that the investigation was completed "at my doctors" (line 20), the ACP does not verbally receipt the information or move to the next question at line 21 (1.5 second silence). Instead, the patient expands the telling stating "cos they've got x-ray" (line 22). A further silence occurs before the ACP initiates repair with "x-ray" at line 23. Ethnographic information supports the claim that there are difficulties here for the ACP. A patient's community and hospital records are separate. As a result, the ACP is unlikely to know exactly what investigations the patient has undergone previously in the community. The ACP therefore initiates repair at a point of uncertainty.

The ACP's other-initiated repair, a partial repeat, occurs in line 23 ("x-ray") in overlap with the patient's "is that" (line 22). The single word "x-ray" is produced with a questioning tone (slow/elongated pronunciation and slight rise in pitch) which is a feature of repair initiators using repetition (Couper-Kuhlen, 2020). While other-initiated repair utilising partial repeats can display an issue with hearing (especially if they repeat the start of a turn) (Svennevig, 2008), full-repeats can claim an issue with understanding or acceptability (Robinson and Kevoe-Feldman, 2010). The recipient of the trouble source turn is puzzled and unable to implement an appropriate next turn (Sacks, 1995). The patient's response "yeah" (line 24) shows that the patient has received the ACP's turn as a repair initiator. While the patient confirms that the ACP has heard and understood what she said about her doctor's surgery having x-ray, the turn also displays an element of uncertainty. The ACP's subsequent candidate answer "or an ultrasound" (line 26) continues the repair sequence, displaying ongoing issues with intersubjectivity and uncertainty regarding the accuracy of the patient's claim that GPs have "x-ray". The ACP's presumption that the patient has had an ultrasound is confirmed in line 30 when the ACP asks, "do GPs have ultrasound" not 'do GPs have x-ray'. In comparison to extract 7.4, where the

ACP's repair initiator progresses the talk, the same is not evident here. The first repair initiator "x-ray" does not add anything new or progress the talk, and while "or an ultrasound" proposes an alternative candidate answer, the patient and ACP remain uncertain and therefore the talk cannot progress. This uncertainty, and the problems the repair-initiation creates for the patient, in responding with the expected confirmation or rejection, are evidenced by the subsequent long gap (0.8 seconds) and the patient's minimal/non-lexical response (line 28). The ACP also directly acknowledges the 'face-threat', which results from pursuing and initiating repair, through the meta-commentary – "am I asking the wrong questions" (line 29-30).

Extract 7.5 shows how the need to obtain accurate clinical information, in order to diagnose and treat the patient appropriately, may require the ACP to initiate and subsequently pursue the repair of patient talk. While these repair-initiators may present a 'face-threat', which could cause suffering, there is evidence in extract 7.5 that work is done to mitigate the face-threat posed, both during and following the ACP's repair initiation. There is a long gap prior to the repair-initiation (line 22) and the ACP initially uses a repeat ("x-ray", line 23), which provides a space for the patient to resolve the interactional trouble themselves. Only when unsuccessful does the ACP initiate the stronger alternative answer – "or an ultrasound" (line 26). Previous research shows that where more than one repair initiator is used, the weakest, least face-threatening form of repair initiator is used first (Schegloff, 2007; Svennevig, 2008). In this extract, it is also significant that the ACP also assumes responsibility for the repair initiation. Following the patient's uncertainty regarding whether she had an ultrasound (line 28), the ACP says in a smiley voice, "am I asking the wrong questions" (line 29). While accounting for other-initiated repair exposes the dispreferred, face-threatening nature of other-initiated repair, in extract 7.5 the turn places accountability for the problem with the ACP. The ACP suggests that participants are not achieving shared understanding because of her own actions, rather than any failing on the patient's part. Subsequently, the ACP clarifies the interactional trouble asking "Do GP's have ultrasound. I don't know" (line 30). Here the ACP acknowledges her uncertainty and role in the interactional trouble – not knowing what radiographic investigations GPs perform. The ACP therefore does work to mitigate the 'face-threat' posed, and potentially minimise any suffering caused by the repair initiation. The ACP's admission regarding her lack of knowledge also provides space for the patient to agree ("I don't know", line

32) and subsequently re-tell her story. In the patient's subsequent re-telling, the patient orients to the need for specificity. Instead of saying the tests were performed at her doctor's (line 20), the patient names the suburb she visited for the investigation (line 32). Similarly, rather than stating "they've got x-ray" (line 22), she states "I went into where the x-ray department is" (lines 37-38). Not only are the details of where the patient went for her investigations more specific, she potentially does work to save both participants' 'face'. In effect, both participants are correct – GPs may not have x-ray or ultrasound but the patient was correct that she went to a location that performs x-rays i.e. the x-ray department. The patient is able to convey the necessary information, and show that she is a competent patient, who is able to communicate medically relevant information.

7.5.3 ACP other-initiated repair during patient talk about symptoms

Extract 7.6 again shows the challenges of obtaining specific clinical information from a patient's account. However, in extract 7.6 the issue relates to the ACP's understanding of the account, with three ACP other-initiated repairs occurring before intersubjectivity is restored. The extract is from a twenty-seven minute consultation between ACP Sarah and Pat, a seventy-five year old man, who has been in hospital for thirteen weeks, following a collapse. Social care has arranged for Pat to view a new property, as his home is not suitable for discharge, and he is reluctant to attend. The patient has delayed the property viewing previously due to pain, and in the present consultation has complained of pain in various locations. The repair sequence occurs eleven minutes forty seconds into the consultation, when the patient initiates talk about a new problem, while the ACP is talking about the property viewing. The interactional trouble relates to the referent of the patient's talk. Both ACP and analyst eventually discover the patient is talking about pain.

Extract 7.6 "What do you mean?"

(CiP26, v.2 L.491) Time 11:48

```
1  ACP    (Pat) ↑honestly if you want to ↑say no. >You say no. =I
2         don't want (yu we'll)< you're not being forced into
3         some[thing. =We're trying to
```

Pat [Oh by the way
(2.0)
Pat I'm not sure what it tis ((Pat raises l.index finger))
(0.9) ((ACP nods head))
Pat but am gonna tell yu. (1.3) Cus: (1.5) I think it's
something to do with the: (1.0) <si:de.> (0.2) I'm
[not] sure.
ACP [Mhm]
(1.5) ((Pat looks down and touches l. abdomen))
Pat But do:wn ere ((Pat looks up towards ACP))
(0.2)
ACP Uhm.
(4.0) ((Pat removes hand from abdomen))
Pat And <that's not> (0.6) >guess<work:.
((Pat shakes head side-side))
(0.7)
ACP What do you ↑mean. >Tell me.< (0.5) >I don't under:stand.<
(1.5) ((Pat stands up))
Pat ◦I can't sa:y.˚ (0.5) Camera
(1.0)
Pat It's he:re. ((Pat touches where pain is))
(0.8)
ACP Righ:t_ (0.8) What >the pain,<
(1.2) ((Pat sits down))
Pat I (↑don't) understand it (0.7) (cos) I kno:w (0.4)
everything what I've had wrong with me.
(0.5)
ACP ◦M:m.◦
(0.8)
Pat I've never had ↑tha:t.
(0.7)
ACP Wha (0.8) What ↑was ↑it, <↑pain:.>
(0.3)
Pat <↑Yeh> (0.3) Sharp pain all: (0.4) all night. (0.9) ↑I
couldn't move:. I couldn't walk. I couldn't go ↑toilet
(1.4)
ACP ↑Have you been for a wee

The interactional trouble occurs following the patient commencing a telling about the presence of a symptom which he is uncertain about (lines 4-10). The telling progresses through lines 8 to 17 with the patient using verbal and embodied means to describe the problem, including stating that the problem is something to do with the side (lines 8-9) and looking down, touching his abdomen, and saying "but down ere" (lines 12 & 13). The ACP concurrently responds with receipt tokens in lines 11 ("mhm") and 15 ("uhm"). A long silence (line 16) follows, during which the patient stops touching his abdomen and gazes at the ACP, suggesting that he is orienting to the telling as complete. The ACP does not take the next turn, continuing to gaze at the patient and pursing her lips, suggesting that she is orienting to the turn as incomplete. The patient subsequently offers a concluding assessment about the information shared - "and that's not guesswork" (line 17). While the ACP's subsequent turn in line 20 acknowledges that the patient's telling is complete, the post-expansion "what do you mean" also initiates repair. In an everyday setting a news receipt which aligns with the emotional tone of the utterance, such as 'oh dear' or 'oh no', may be adequate, but in this setting the ACP has to determine "what it tis" (line 6) is referring to, and provide an adequate clinical response.

The ACP's first repair initiator in extract 7.5 is the open-class repair initiator 'what do you mean' which, while not locating the source of the trouble, does display that the trouble relates to understanding the patient's previous talk. Following the ACP locating responsibility for the interactional trouble with herself not the patient ("I don't understand", line 20), the patient acknowledges the repair initiator stating "I can't say" (line 22). The patient then proceeds to offer a multimodal repair solution that includes standing up, facing the ACP, touching his groin and claiming "it's here" (line 24). The patient's embodied repair solution does not however, restore intersubjectivity. Following acknowledging with "right" (line 26) that the patient has responded (and offered a repair solution), the ACP pursues the repair by initiating a second repair initiator – "what the pain". In comparison to "what do you mean" (line 20), which did not locate the source of the trouble, the category specific question "what" displays that the lack of understanding now relates to the object (referent) of the talk and "the pain" offers a candidate answer. Although the patient continues his problems-telling, claiming "I don't understand" (line 28) and that he has "never had that" (line 33), he does not explicitly acknowledge the ACP's repair initiation in line 26. The ACP still does not have the information necessary to provide a

clinical response at the transition relevance place in line 34 and the ACP responds with a third other-initiated repair. "What was it pain" (line 35), is almost identical to the other-initiated repair in line 26; however, the post-expansion fits clearly with the patient's previous turn, identifying the trouble source as the final word – "that" (line 33). The patient subsequently offers a repair solution (lines 37-8), which restores intersubjectivity and progressivity. This repair solution allows the ACP to continue assessment, and determine if the patient is medically fit and able to go on the proposed home visit.

Responding appropriately to patient's symptoms is a necessary component of high quality care, and in extract 7.6 other-initiated repair facilitates an appropriate response to the patient's talk. However, the multiple repair initiations do again present a potential 'face-threat'. The initial other-initiated repair "what do you mean" (line 20) displays an issue with understanding. In his analysis of everyday interaction and interaction between social workers and clients, Svennevig (2008) found that the use of 'what do you mean' as a repair initiator tends to be avoided. He concluded that this is because it hinders progressivity, and also displays a lack of competence in the trouble source speaker that could be face-threatening. There is also the issue of multiple ACP other-initiated repair within the sequence. To initiate a second other-initiated repair potentially threatens the status of both participants as competent co-participants to the interaction. Each subsequent ACP repair-initiation therefore could potentially increase the face-threat posed (Pilnick *et al.*, 2021).

While a 'face-threat' is present, in extract 7.6 the ACP again does work to mitigate it. Following the ACP's first repair-initiator ("what do you mean", line 20), which potentially exposes the patient's lack of competence, the ACP's expansion "I don't understand" (line 20) locates the breakdown of intersubjectivity as her responsibility: it is a lack of understanding on her part, rather than a problem of the patient producing something that is universally understandable. The patient's account subsequently confirms that not specifying the problem is related to embarrassment, due to environmental factors ("I can't say (0.5) camera"), not a lack of willingness or competence. The ACP's second repair initiation is preceded by "right" (line 26), which perhaps suggests that some features of the turn are understood, for example, the location of the patient's problem. The ACP's subsequent repair-initiator, a

question containing a candidate answer ("what the pain", line 26), potentially allows the patient to respond without naming the problem which he regards as embarrassing. The timing and construction of the final repair initiator ("what was it pain", line 35), also suggests considerable care is taken to balance obtaining the necessary clinical information, and to minimise any suffering that may result from another potentially face-threatening other-initiated repair. While the ACP is still unlikely to be aware of the referent of the patient's talk in lines 28-29, she receipts the talk with a continuer ("mm", line 31), suggesting that intersubjectivity has been restored. Using an acknowledgement token in this way, provides for the possibility that the patient will specify what the referent is in subsequent talk, and therefore avert the ACP having to initiate further repair (Pilnick *et al.*, 2021). When the ACP again addresses the ongoing issues regarding the referent of the patient's talk, the repair initiation "what was it pain" (line 35) immediately locates the trouble source in the last word of the patient's previous turn ("that", line 33). While the ACP's turn clearly identifies the trouble source, the turn potentially creates ambiguity about where the interactional trouble originated, patient or ACP. "What was it pain", in line 35, is a reformulation of the repair-initiator "what the pain", from line 26. If the ACP's reformulation is displaying some responsibility for the ongoing interactional trouble, the threat to the patient's 'face' is minimised. Certainly, following the final repair initiation, the patient resolves the interactional trouble specifying the problem, the duration of the problem and the impact of the problem on him ("sharp pain all: (0.4) all night. (0.4) I couldn't move:. I couldn't walk. I couldn't go toilet", line 37-38). The referent is no longer ambiguous, intersubjectivity is restored by the patient, and the patient resumes his role as competent historian.

7.6 Discussion

This final analysis chapter focused on ACP other-initiated repair of patient talk. In comparison to previous analysis chapters, which focus on ACP responses to specific activities, repair is one of the major organising features of interaction, which allows talk to progress (Schegloff, 2007). Other-initiated repair is also one area where responding compassionately may be difficult. Other-initiated repair is described as a dispreferred action (Schegloff, Jefferson and Sacks, 1977), which can threaten the 'face' of participants because it draws attention to the speaker's ability to sustain intersubjectivity and progressivity (or make

themselves understood) (Robinson, 2006b). Threatening the 'face' of participants, could- in the context of the importance of 'the small things'- potentially be described as causing suffering and therefore uncompassionate. Analysis of ACP open-class repair initiators, occurring predominantly when the ACP was engaged in another activity (extracts 7.1 – 7.3) and other forms of other-initiated repair which occurred during patient talk (extracts 7.4 – 7.6) show that sometimes, potentially face-threatening other-initiated repair may be necessary for ensuring intersubjectivity, progressivity and safe, effective care. As will be discussed, these findings raise questions about the straightforward distinction between technical care and compassion implied in policy (Prime Minister's Commission on the Future of Nursing, 2010), and the application of generic communication practices, such as attentiveness, talking and listening, that are identified in policy (Department of Health, 2008) and research (see Figure 2.2, p.36).

Analysis of both ACP open-class repair initiators, which occur predominantly when the ACP's main focus of attention is on a concurrent task, and other forms of ACP repair initiation, which occur during patient talk, show that in certain contexts there may be good reasons why ACPs do not consistently interact in the ways nursing literature suggests are compassionate (for example, see Chambers and Ryder, 2009). In extracts 7.1 to 7.3 ACP open-class repair initiators, which occur predominantly in talk when the ACP is involved in a concurrent task, such as a procedure or examination, show that a joint focus of attention is not always possible. When the ACP's main focus is a task, which requires a certain level of concentration and attention, the ACP may not be able to fully attend to the patient's talk. The talk may however, remain the patient's main involvement. With an emphasis on listening and talking (Department of Health, 2008; Commissioning Board Chief Nursing Officer and DH Chief Nursing Adviser, 2012) policy implies attentiveness to patient talk is a central feature of compassion. Similarly, both patients and staff regularly identify attentiveness and listening as important components of compassionate care (Bray *et al.*, 2014; van der Cingel, 2011; Way and Tracy, 2012). Interactionally, listening is also a fundamental requirement of the turn-taking system, the maintenance of intersubjectivity, and the progressivity of the interaction (Sacks, Schegloff and Jefferson, 1974). However, performing an intricate task such as cannulation accurately and safely will also reduce patient distress and suffering. To focus

exclusively on a patient's talk as evidence of compassion may therefore not be possible or desirable.

While the first part of the chapter focused on ACP open-class repair initiators and the difficulties of attending to patient talk during procedures, extracts 7.4 to 7.6 present data where ACPs initiate repair of patient talk during history-taking. In all cases, the repair is undertaken in the pursuit of specific clinical information: the name of an emollient the patient has been using (extract 7.4); to ascertain the results of previous investigations (extract 7.5); and to ascertain what the 'problem' is (extract 7.6). Particularly in extracts 7.5 and 7.6, where obtaining the clinical information occurs over a number of turns, the ACP draws attention to difficulties understanding the patient's talk. In these extracts, the initiation of repair may threaten the patient's 'face', in terms of someone who can maintain intersubjectivity and progressivity within a clinical encounter i.e. someone who has the competency to possess knowledge of their symptoms and articulate this knowledge. Previous research has shown in some clinical settings, when patient talk is hard to interpret, healthcare professionals may pass over talk that is not understood (Pilnick *et al.*, 2021). By doing this, the healthcare professional essentially avoids threatening the participant's 'face'. However, in the data presented in this chapter, avoiding initiating repair may have resulted in the ACP failing to obtain information necessary for effective clinical care. Accurate diagnosis and treatment are likely to alleviate suffering and could therefore be identified as the long-term compassionate action. The provision of longer-term, safe and effective care may therefore sometimes override 'face' considerations and generically attributed features of compassionate interaction. These findings suggest that the straightforward relationship between clinical care and compassion which is implied in policy may not actually be possible. Potentially, these tensions between long-term clinical care and short-term compassionate interactions could create conflict for nurses. In relation to other policy recommendations, such as respecting the wishes and choices of people with intellectual disabilities, other conversation analysts have claimed that some policy recommendations ultimately present professionals with unworkable dilemmas (Antaki and Webb, 2019; Pilnick *et al.*, 2010). Consideration perhaps needs to be given to the idea that, in some contexts, generic assumptions regarding compassionate practice, such as "listening is as important as what we say or do" (Commissioning Board Chief Nursing Officer and DH Chief Nursing Advisor, 2012, p.13), may create unattainable ideals.

There may be both good interactional and institutional reasons for ACPs not to adhere to generic recommendations in certain contexts, where the result could impede ongoing interaction and/or safe effective care.

As in previous chapters, focusing on ACP other-initiated repair of patient talk also shows that what is and is not considered compassionate depends on the context. By this, I mean that while other-initiated repair when patients talk about symptoms, investigations or previous treatments may threaten the patient's 'face', causing embarrassment and minor suffering, in other contexts the other-initiated repair can support the patient's telling. In extract 7.4, for example, where the patient has difficulty identifying the emollient she has been prescribed, the patient's self-repair and embodied movements suggest she is looking for assistance in naming it. There is evidence throughout my data that ACPs are attentive to patient talk and when a patient displays that they are having difficulty providing information, often specific medical information or something that is delicate, ACP's offer candidate understandings. These candidate understandings can be accepted or rejected by the patient and progressivity is resumed. In these contexts, when the ACP's candidate answer appears to support the patient to overcome an interactional difficulty, the repair might be seen as a compassionate means to deal with a knowledge asymmetry relating to medical/technical language. As discussed in previous chapters, this shows again the problem with deciding *a priori* that specific communication practices represent compassion, without a consideration of the interactional and institutional context.

This chapter also shows how managing other-initiated repair is a delicate interactional task, and ACPs appear to attempt to mitigate any negative consequences. While open-class repair-initiators (extracts 7.1 to 7.3) did not necessarily threaten the patient's 'face', they potentially threatened the ACP's 'face' as someone who attends to the patient's talk. In the present data set, ACPs tended to follow the open-class repair initiator by continuing the topic of talk that was contained within the patient's initial trouble-turn. While pursuing subsequent talk may in some cases be due to medical relevance, by displaying subsequent attentiveness the ACP is also showing that they are not dismissive of the patient's talk or the topic. In ACP other-initiated repair, when the patient was providing clinically relevant information, attempts to minimise any negative

consequences of repair initiation were also evident. These strategies included the ACP attempting to avoid initiating repair in the first instance. In extract 7.6 the ACP gives minimal responses during the patient's telling, which previous research has suggested may be done in the hope talk will become clear as it progresses (Antaki *et al.*, 2019). However, delaying repair can also be problematic, because it may become harder to identify which part of the talk has not been understood and it can expose that the recipient has not understood the talk over a number of turns (Pilnick *et al.*, 2021). Following other-initiated repair in my data, ACPs also attempted to minimise the potential face-threat, by offering accounts where they accepted responsibility for the breakdown in intersubjectivity. That is, they attributed responsibility for the breakdown in intersubjectivity to their understanding, rather than the patient's telling (extract 7.6), or to their actions, for example, the inadequacy of their questions rather than the patient's answers (extract 7.5). As already discussed, the ACP's other-initiated repairs may be necessary for intersubjectivity regarding symptoms or previous investigations and treatments. They are potentially facilitating safe and effective care, which could be regarded as compassionate in the long-term. However, the ACPs' attempts to minimise the face-threat posed by their other-initiated repair of the patient's talk could again be one of the 'small acts' described in both policy (Alexander *et al.*, 2014; Department of Health, 2008; Department of Health, 2015) and previous research (Bramley and Matiti, 2014; Straughair, Clarke and Machin, 2019; Tierney *et al.*, 2016). The practices ACPs use to reduce the face-threat posed by clinically necessary other-initiated repair, are not the affiliation or the comforting discussed in previous chapters. However, these practices may still be a way of minimising suffering, when the ACP has to engage in interactional practices, which may cause trouble for patients or leave them feeling inadequate or incompetent in some way. These 'small acts', at a much more micro-interactional level than is generally considered in policy, show the sophisticated skill-set ACPs use to manage the long-term minimisation of suffering, alongside the provision of effective clinical care and the addressing of immediate interactional concerns. Once again these findings raise questions about suggestions that either observers using checklists to measure compassion or patient self-report measures can easily distinguish compassionate and uncompassionate interaction.

The starting point for the present chapter was other-initiated repair, an action which could potentially cause suffering. However, similar conclusions emerge as

in previous chapters, regarding the enactment of compassion and the dilemmas healthcare professionals have to navigate. Again, generic recommendations regarding compassionate practices may not always be helpful: as my analysis has shown, interactional practices are not universally 'good' or 'bad', compassionate or uncompassionate. While other-initiated repair may threaten the 'face' of a patient, there may also be times when other-initiated repair shows that the ACP is attending and potentially assists the patient in providing clinically-relevant information. Even in episodes where the ACP exposes the patient's lack of knowledge regarding their symptoms, and ability to convey this information, ACPs use practices to attempt to minimise any harm that may result from the repair initiation. These practices show the sophisticated skill set healthcare professionals use to navigate sometimes seemingly unworkable dilemmas. ACPs are navigating the need to provide safe, effective care which minimises long-term suffering, the need to maintain intersubjectivity and progressivity, and the need to treat the patient with dignity and respect. The navigation of all these competing interactional and institutional demands suggests that a simplistic dichotomy between what is considered compassionate and uncompassionate nursing care, may not reflect what actually occurs in practice. The questions that this analysis raises will be considered in the concluding chapter.

Chapter 8 Conclusion

The aim of this thesis was to explore the enactment of compassion in interaction between advanced clinical practitioners (ACPs) and older patients. In this concluding chapter, I will provide a summary of my thesis chapters, before discussing the contribution this research makes to theory and practice regarding compassion in healthcare. From a practical perspective, I will argue that this thesis provides a detailed understanding of some of the micro-level professional practices that may constitute compassion. However, I will argue that this thesis' main contribution is to healthcare theory, by showing that within nurse-patient interaction, compassion is an interactionally complex activity, with professionals facing interactional and institutional dilemmas, which contemporary policy conceptualisations of compassion fail to acknowledge.

8.1 Summary of thesis chapters

The literature review explored how compassion is conceptualised in healthcare, and included a review of compassion in theory, policy and empirical research. Within this literature, different conceptualisations of compassion were identified including compassion as a value, a characteristic of the healthcare professional and a psychological process or state. While there were variations regarding which values comprise compassion, and the importance afforded to different psychological processes in producing compassion, there was a consensus that the respective features of compassion were exhibited within interaction. However, there were also variations regarding which communication practices were seen to display compassion. The interactional features claimed to display compassion were extensive and consisted of both verbal and embodied communication practices (Figure 2.2, p.36) including, for example, listening, touch and the 'small things'.

While the literature review identified a range of communication practices associated with compassion, these interactional features originated predominantly from studies exploring healthcare professionals' and patients' perceptions and experiences of compassion. These interactional features of compassion are therefore founded on what people think or say happened, rather than what actually occurs in practice. Some of this research has been used to

develop self-reported and patient-reported measures of compassion. However, these measures apply *a priori* definitions of compassion, which decontextualise the interactional features of compassion. The literature review therefore identified limited exploration of how the communication practices that supposedly display compassion work within their interactional context, or how compassion is actually enacted within the context of nurse-patient interaction. The present research therefore aimed to explore the enactment of compassion within its interactional context.

Chapter three introduced conversation analysis as the qualitative inductive approach that would be used to explore the enactment of compassion within ACP-patient interaction. With foundations in Goffman's (1983) notion of an interaction order, and Garfinkel's (1984) ethnomethodology, conversation analysis investigates interaction within context. Rather than focusing on what participants think occurred in an interaction or applying *a priori* criteria regarding the interactional features comprising compassion, conversation analysis focuses on the methods that participants use to achieve intersubjectivity and social actions. I therefore proposed conversation analysis as an appropriate approach to explore the enactment of compassion within its interactional context, and in chapter four I outlined the methods used to undertake the detailed inquiry conversation analytic research requires. Firstly, I described the collection of audio-visual recordings of naturally-occurring interaction between ACPs and older people in both healthcare of the older person (HCOP) wards and reablement units. Secondly, I outlined how analysis of participants' interaction, which focused on the structure and organisation of talk, was undertaken using recordings and transcripts. I also discussed how adopting ethnomethodological indifference allowed me to avoid making judgements about the value of compassion or specific interactional practices. As such, I was able to focus on what ACPs and patients were actually orienting to in their talk.

Chapter five, the first analysis chapter, focused on ACP responses to patient accounts of problems and troubles. Patient accounts of problems and troubles are a potential location where the expression of suffering may occur, and where a compassionate response may be required. I identified a number of different practices for affiliating with the patient's problem-stance or with the patient's

feelings regarding the problem. This affiliation appeared to be an accountable action and I presented data where, when affiliation was not forthcoming, the patient pursued affiliation and a problem-solution.

Analysis of these extracts showed that ACP responses were adapted to the interactional context, and bore only limited resemblance to the definitions of compassion found in policy (see Table 2.1, p.17), and commonly used in healthcare literature (see Table 2.5, p.49). Adapted from existing research and definitions of compassion, I developed a two-part working definition of compassion as:

"A nurse's explicit or implicit acknowledgement of the patient's suffering and/or the observable actions that the nurse undertakes (in an attempt) to reduce or alleviate suffering."

The findings in this chapter suggested that in the HCOP setting, alleviation of suffering may not always be possible. However, ACPs acknowledged patient suffering, either through affiliation with the patient's problem stance or through affiliation with the patient's feelings. In extracts where the ACP affiliated with the patient's feelings, through, for example, an empathic response, interactional evidence was provided of the ACP verbalising (van der Cingel, 2011) or displaying explicit understanding regarding a patient's suffering (Sinclair *et al.*, 2016a; van der Cingel, 2011). While a number of authors have suggested that displays of explicit or implicit understanding assist in alleviating suffering (Durkin, Jackson and Usher, 2021a; Sinclair *et al.*, 2016a; Tehranineshat *et al.*, 2019b; van der Cingel, 2011), evidence from the interactional data collected was more circumspect. Upgraded assessments by the patient following a display of explicit understanding by the ACP, suggest that the patient is concurring with the ACP's assessment. These responses show the ACP's response is received as adequate, however, they are not conclusive proof that the affiliation alleviated suffering. Nonetheless, the data do suggest that acknowledging suffering is an important component of ACP responses to patient problem-tellings, and that ACPs may be held accountable for not providing these responses.

Chapter five also identified that ACPs used a number of different practices that acknowledged patient suffering, either through affiliation with the patient's

stance or their feelings. I showed that while implicitly acknowledging the patient's suffering, such practices also deferred to the patient's epistemic rights over their symptoms and feelings, and avoided exposing the patient's limitations. I suggested that these context-sensitive practices for affiliating with patients' problems show how ACPs balance acknowledging patient suffering, with other values such as respecting the patient's knowledge and protecting their dignity. In the context of healthcare, particularly healthcare of the older person, balancing these different values may be important in preventing further harm and suffering. In addition to showing the sophisticated skill-set that ACPs use to respond to both institutional and interactional needs in the moment, the findings start to raise questions about the dichotomy between compassionate and uncompassionate care implied in policy since the Francis Inquiry (2010; 2013a). Given the variety of practices used to acknowledge suffering, I began to raise questions about claims that generic recommendations regarding compassion can be implemented, or that observational scales can be meaningfully used to measure compassion.

Chapter six is based on the analysis of a collection of ACP responses to patient complaints, which developed from the larger collection of patient accounts of problems and troubles. The first part of the chapter explored ACP responses to patient complaints about a transgression by the ACP during the interaction. As identified in relation to ACP responses to patient problem-tellings, ACPs aligned and affiliated with the complaint, acknowledging the patient's suffering. However, the practices that ACPs used to perform this affiliation varied, both between the complaints, and from those discussed in relation to patient problem-tellings. Practices included explicit apologies for the transgression, displays of understanding regarding the patient's stance, and implicit acknowledgements of the patient complaint through, for example, an upgraded correction of the complained-about talk. Again, I suggested that the practices identified which acknowledge suffering are more nuanced than the generic features identified in previous research, and raised questions about checklist-type recommendations regarding compassionate interaction. I also proposed that these ACP responses to patient complaints about a transgression provide concrete examples of the interactional 'small things' described in previous research (Bramley and Matiti, 2014; Straughair, Clarke and Machin, 2019; Tierney *et al.*, 2016). In the scheme of a healthcare interaction, apologising when a patient complains that the ACP has touched them with cold hands may

appear relatively insignificant. However, ACPs acknowledging and affiliating with a patient complaint about their minor transgression potentially displays respect for the person, and assists with building social cohesion (Heritage, 1984b; Lindstrom and Sorjonen, 2013). These interactional 'small things' may therefore underpin incredibly important 'big things' in interactions between healthcare professionals and patients.

The second part of chapter six explored ACP responses to patients' complaints about third parties. Again, analysis of the data suggested that affiliating with the complaint was an important component of compassionate interaction. In all cases, when the ACP explicitly affiliated with the complaint, the patient accepted the response as adequate and the consultation progressed. However, in the case of complaints about third parties, patients appeared to hold ACPs accountable for what exactly their talk affiliated with. There was some evidence that when the ACP did not explicitly affiliate with the complaint about a third party, the patient pursued the complaint. There was also evidence to suggest that there may be good institutional reasons for ACPs avoiding explicit affiliation when a patient complains about a third party, especially when this could potentially influence future care. ACPs displayed a number of practices that avoided fully affiliating with patient complaints about other members of staff. These included minimal receipts, change of state tokens and the offering of problem solutions, such as offering pain relief or performing care differently. When ACPs did affiliate with a complaint, they also used mitigation to justify the transgression. In addition to healthcare professional affiliation with a complaint about a third party potentially threatening the credibility of healthcare and professional relationships (Ruusuvuori and Lindfors, 2009), there is a risk that patients may refuse to engage in fundamental care that could alleviate further suffering. I presented an extract where the ACP fully affiliated with a patient complaint about a member of staff in a care home and the patient stated that they would not return there. In the case of patients' complaints about third parties, avoiding short-term responses which explicitly affiliate, may reduce the risk of patients refusing fundamental care, and therefore facilitate the provision of care that reduces long-term suffering. This contrast between the provision of what could be viewed as a short-term compassionate response, and talk that promotes the provision of fundamental care and potentially prevents future suffering, shows the workplace dilemmas ACPs have to navigate.

In this chapter, I also showed that short-term orientations are prioritised over longer-term ones when patients display visible distress. Although rare in the data collected, patient distress demonstrates suffering in the moment, rather than a report of suffering at another time. In these contexts, I showed how ACPs respond to the patient's emotional tone, treating resolution of the distress as a priority activity (Pilnick *et al.*, 2021). While in other data analysed, I raise questions about whether ACPs' actions alleviate suffering, in the context of distress, ACPs appear to perform actions to alleviate suffering, rather than just acknowledge suffering.

The final analysis chapter explored ACP other-initiated repair, or how the ACP responds when there is a problem with hearing or understanding the patient's talk. The first part of this chapter focused on ACP open-class repair initiators, which occur predominantly in the dataset when the ACP is concurrently involved in a procedure. I showed that, in these situations, the ACP and patient have a different focus of attention. While talk remains the main focus of attention for the patient, the ACP's attention is on completing a task, which requires a certain level of skill and concentration to be performed safely and successfully. As such, the attention to talk which is required to maintain intersubjectivity and the progressivity of the interaction may not be possible, and when the patient talks the ACP has to initiate repair. I suggested that the attentiveness to patient talk implied in policy (Department of Health, 2008; Commissioning Board Chief Nursing Officer and DH Chief Nursing Adviser, 2012) and research exploring patients' and healthcare professionals' experiences of compassion (Badger and Royse, 2012; Bray *et al.*, 2014; Sinclair *et al.*, 2016a; van der Cingel, 2011; Way and Tracy, 2012), cannot be applied to all contexts. When performing procedures such as cannulation, safe and effective care, which prevents additional harm and suffering, may be prioritised over generic recommendations such as attentiveness to patient talk.

The second part of chapter seven focuses on ACP other-initiated repair that occurs during patient talk. In the extracts presented the ACP's other-initiated repair occurs in the pursuit of obtaining medical information from the patient regarding symptoms, or previous investigations or treatments. As such, these other-initiated repairs were necessary for fulfilling the clinical agenda, and ensuring safe, effective care. Other-initiated repair can however, draw attention

to participants' (lack of) ability to maintain intersubjectivity and progressivity within the clinical encounter. As such, other-initiated repair can potentially threaten the 'face' of participants causing embarrassment and suffering (Robinson, 2006b; Svennevig, 2008). In some scenarios, 'passing over' the repairable could avoid threatening the participant's 'face' (Pilnick *et al.*, 2021). However, in the pursuit of long-term safe effective care, through the clarification of a symptom, investigation or medication, the ACP prioritises the prevention of long-term suffering over immediate 'face' considerations.

The analysis of ACP other-initiated repair suggested that ACPs do work to minimise any harm that may result from exposing a difficulty with hearing or understanding patient talk. In relation to open-class repair initiators during procedures, I showed that following their repair initiator, the ACP appeared to do work to pursue the patient's topic of talk. While the patient's talk may be pursued due to medical relevance, I proposed that pursuing the topic of talk also potentially saves the ACP's 'face', and demonstrates attentiveness in response to the potentially uncompassionate act of not attending or listening. The ACP's subsequent attentiveness also recognises the patient as an active participant in the consultation. In relation to repairs of patient talk undertaken in the pursuit of specific clinical information, firstly, there was evidence to suggest that ACPs attempted to avoid other-initiated repair. Secondly, there was evidence to suggest that, if repair became necessary, ACPs attempted to mitigate any potential 'face' threat by, for example, accepting responsibility for the interactional trouble. Once again, these practices may seem incredibly small, and come in the context of talk which could at first glance be described as uncompassionate. However, investigation of other-initiated repair shows that ACPs are balancing the complexities and contradictions of minimising long-term suffering through the provision of safe effective care, and engaging in short-term interaction, which does not undermine the 'face' and competency of the patient. As has been shown, the provision of safe, effective care is prioritised. However, 'small acts' such as mitigating any harm caused by practices such as other-initiated repair become incredibly important acts.

While there was evidence that other-initiated repair of patient talk about symptoms, investigations and treatments created interactional trouble and potentially threatened the 'face' of the patient, there was also evidence that

other-initiated repair supported patient talk. Where patients actively sought support to repair their talk, especially when the information was in the medical domain e.g. a drug name, resolution occurred without any apparent threat to 'face'. In addition to showing that ACP practices are contextual, analysis of ACP other-initiated repair also showed that, within concurrent talk, there could be practices that caused suffering and practices that attempted to mitigate this suffering. Within sequences of other-initiated repair, there was evidence of ACPs attempting to mitigate any potential 'face-threat' by, for example, accepting responsibility for the interactional trouble. I proposed that, while the need to obtain accurate information may result in the initiation of a potentially face-threatening, other-initiated repair, these mitigations were a compassionate practice, which potentially protected the patient's 'face'. There may therefore be problems with assuming that a specific sequence of interaction can be categorised as entirely compassionate or uncompassionate.

8.2 Critical appraisal of the thesis

Before outlining the limitations of this research, I will briefly outline what this research set out to do, and outline what it cannot do. Firstly, while the research can show practices that ACPs use to perform actions such as acknowledging suffering, the research cannot provide evidence of universal practices, which can be used in a checklist-like fashion to assess or teach healthcare professionals or students. Secondly, and closely related to the first point, the research cannot prescribe what makes 'good' or 'bad' communication. Instead, this research provides evidence about what happens in the interaction between ACPs and patients within specific contexts. Finally, this research cannot identify what impact macro-contextual factors such as staffing and lack of time had on the interaction. What this research does, however, do is provide an exploration of compassion within its interactional context, rather than relying on what people think or say they do, or on measures which associate compassion with certain pre-selected interactional features. As a result, this thesis has generated findings in two areas, which arguably would not be possible with other approaches. Firstly, using conversation analysis has identified communication practices that facilitate compassionate care. Secondly, this thesis has shown how the generic communication practices, such as listen or empathise, seen in contemporary conceptualisations of compassion, overlook the institutional and interactional dilemmas healthcare professionals face.

Consideration does however, need to be given to the transferability of findings, and whether, in retrospect, the study could have been designed differently. Firstly, questions need to be addressed regarding the amount of data collected. Due to a number of factors, including lengthy ethics procedures, service reconfiguration and the timeframe for a research thesis, the amount of data collected in general, and that collected from the reablement unit in particular, were less than initially planned. In total, twenty-seven recordings containing five hours and seventeen minutes of data were collected, not the forty recordings originally estimated. From a methodological perspective, conversation analysis is not concerned primarily with the frequency of practices but with providing detailed descriptions and analysis of the practices people use to maintain mutual understanding and social order (Sacks, 1995). Conversation analysis adopts a 'specimen approach', with this thesis showing a number of practices associated with the acknowledgment of suffering, and a number of dilemmas with contemporary conceptualisations of compassion in nursing. In addition, from a practical perspective, questions are raised about whether more data could have been incorporated into a conversation analytic thesis. Conversation analysts acknowledge that transcription and analysis are time-consuming (Parry, 2010). I would therefore suggest that collecting further interactional data in busy healthcare settings would not have been necessary or ethically appropriate. Even with twenty-seven consultations I could not provide an exhaustive analysis of the data, and plenty of phenomena remain to be analysed.

In addition to considering the amount of data collected, attention also needs to be given to the sample the data were obtained from. As shown in Table 4.2 (p.95), the sample includes a broad collection of cases, including consultations in a number of different settings, consultations with patients experiencing confusion who did not have capacity to give consent (n.2), consultations where a companion was present (n.4), and consultations where it was the first contact between the ACP and patient in the recording (n.2). Many of these numbers are small. For example, due to service re-configuration, only two recordings were obtained from reablement units. Whether these variations in the consultations recorded impacted on the practices identified is unclear. It seems likely that there will be variations in ACP-patient interaction, depending on the location and factors such as a participant's underlying capacity or condition. However, the

aim of the present study was not to identify differences according to such characteristics, but to explore the enactment of compassion. As mentioned above, any specimen is a 'good' one (ten Have, 2007) and showing that nurses navigate interactional and institutional dilemmas when responding to suffering in a broad collection of cases, suggests that these dilemmas and responses will occur across a wider variety of healthcare settings. There are many tasks in healthcare where healthcare professionals have to navigate both the delivery of safe, effective care, whether that be cannulating or assisting a patient to move, and the immediate interactional context. Similarly, patient complaints about third parties will occur in a variety of healthcare settings. While the actual practices identified within this thesis will not apply to all contexts, this thesis does present a range of practices which healthcare professionals can consider the appropriateness of in different contexts.

While the broad collection of cases potentially adds strength to the claim that conceptualisations of compassion present dilemmas for healthcare professionals, if the project were to be repeated, recruiting more ACPs would be beneficial. While there is an acknowledgement within conversation analysis that a single case is enough to show that a practice actually occurs and is relevant in a specific context (Schegloff, 1987a), having more than one practitioner helps guard against "idiosyncratic styles" (p.160) of practice (Drew, Chatwin and Collins, 2001). The present study did however, contain more than one healthcare practitioner and similar practices were identified among the healthcare practitioners. For example, avoiding or mitigating responses to third-party complaints was not restricted to just one ACP, suggesting that while the individual practices may vary, an orientation to not emphasising and blaming colleagues was not idiosyncratic. However, if the project were to be repeated, consideration would be given to expanding the inclusion criteria to include ACPs working in other medical areas or other specialist nurses.

Consideration also needs to be given to the impact recruitment processes had on the data collected and the credibility and transferability of findings. As discussed in section 4.7.2 (p.86), in collaboration with the researcher, ACPs predominantly identified which patients met the recruitment criteria in terms of patient acuity and distress. ACPs therefore had some determination over which consultations were recorded. Conversation analysis prioritises the collection of

naturally-occurring data (Perakyla, 2004) therefore, in comparison to other methods, selection bias poses less of a potential issue. Given the study aimed to identify the skills ACPs use in their everyday practice, allowing ACPs some control over which consultations were recorded, potentially allowed the collection of data where these skills would be exhibited. However, on reflection, the level of ACP determination over which consultations were recorded, may have resulted in more 'delicate' or 'difficult' conversations being avoided. Potentially, other healthcare staff identifying eligible patients, would have allowed for the identification of both different forms of patient suffering and other responses used by ACPs. In future studies, consideration would be given to the completion of further preliminary work, in order to support other healthcare staff in the identification of eligible patients.

The impact of giving patients a choice regarding whether the consultation was video- or audio-recorded also requires consideration. The option for audio-only recordings appeared to increase participation. Ten of the twenty-seven recordings collected are audio-only, with patients reporting that they did not want to be video-recorded due to acute illness and hospitalisation resulting in changes in their appearance. Similar concerns about the acceptability of video-recording consultations, when appearance had changed, also emerged in Pino et al's (2017) work exploring stakeholders' views of video-based research. While audio-recordings are described as providing a "good enough" record of what happened for analysis (Sacks, 1984, p.26), consideration does need to be given to what impact the number of audio-only recordings has on the credibility and transferability of findings. The issue with audio-only recordings is that there is no record of embodied action or concurrent multi-activity. As a result, there can be difficulties regarding the certainty of claims regarding what ACP and patient are orienting to in audio-only recordings. In extract 7.2, for example, there are a number of long silences, and whether these are due to concurrent activity or interactional trouble is harder to determine conclusively. In future studies, further consideration would be given to how I introduce and phrase the methods of recording available during recruitment conversations, and whether video recordings are the default option.

Questions for future studies also emerge about achieving a balance between the quality of recordings, and collecting naturally occurring data. While my

presence may have improved the quality of recording, it is likely that being present would also have changed the dynamic of the interaction. However, in future projects, further consideration would be given to the equipment used. Limited space meant that it was difficult to place cameras in positions where they were unobtrusive. The possibility of having equipment designed to fit cameras to hospital furnishings, or using smaller cameras with a wider angle lens would be explored.

A critique conversation analysis sometimes receives is that recording influences the interaction, and limits the researcher's ability to collect 'naturally occurring' data. This critique needs to be considered in relation to the present study. Firstly, some ACPs and patients reported that they quickly forgot, or did not notice that the recording equipment was there. This anecdotal evidence suggests that recording may have had limited impact on the actual interactions recorded. Other researchers have presented evidence suggesting that participants quickly forget that the camera is present (Parry, 2010). There were however, times when recording equipment was oriented to during interactions. Some of these extracts are included in the present thesis, especially in relation to privacy and examinations. While the camera, for example, may have created the misunderstanding in extract 7.6, the repair practices used are unlikely to be affected by filming. As other conversation analysts acknowledge, while the camera may influence topics of talk, they are less likely to influence the features that are the focus of talk – those practices that usually go unnoticed by participants (Clayman and Gill, 2004). Secondly, and relatedly, it is possible that ACPs may have attempted to communicate in ways that textbooks and guidance suggests is compassionate. However, given the finding that current conceptualisations of compassion and generic recommendations such as 'display empathy' are not used in all contexts, due to other interactional and institutional contingencies being oriented to, there is limited evidence to suggest that ACPs attempted to communicate in ways which would appear compassionate.

8.3 Contributions to theory regarding compassion and nursing practice

Within this thesis, I presented findings that build on previous research suggesting that compassion occurs within interaction (see Appendix 7 for a full

list of these studies). I started to outline some of the practices that nurses use to display compassion. In relation to patient problem-tellings, for example, I show how ACPs use different affiliative practices to acknowledge patient suffering (see extracts 5.1 to 5.3). However, this investigation of compassion within its interactional context also adds new knowledge, and engages with theoretical debates regarding conceptualisations of compassion in nursing practice.

Firstly, the findings identify and develop thinking regarding the position of 'small acts' within conceptualisations of compassion. Within the literature review, the meaning attributed by researchers to the notion of 'small acts' varied. In some instances 'small acts', such as making a cup of tea or purchasing a patient's favourite soap, were attributed to the altruistic, virtuous nurse or healthcare professional (Durkin, Gurbutt and Carson, 2019; Smith-MacDonald *et al.*, 2019). In other research, what exactly these 'small acts' consisted of was not clarified (Bramley and Matiti, 2014; Graber and Mitcham, 2004). There was, however, a sense that the phrase 'small acts' encompassed the difficulty explicating the practices entailed in compassion. The present research outlines what some of these 'small' but often unseen interactional practices consist of. In all chapters, interactional practices that potentially minimise suffering, but could be regarded as 'small' or relatively insignificant, were identified. Apologies for relatively minor transgressions, such as touching someone with cold hands (extract 6.1) may appear relatively insignificant. However, affiliating with, accepting responsibility for and apologising may be important means of acknowledging suffering, and facilitating care. Similarly, mitigating any embarrassment or face-threat that clinically necessary other-initiated repair poses may appear relatively small. However, in the case of older patients, whose dependence on others for the provision of physical care may be increasing, practices which ensure that patients are not left feeling inadequate or incompetent potentially increase wellbeing, satisfaction, and assist in building working relationships. These findings therefore not only provide evidence regarding what 'small acts' may entail interactionally, they also show the significance of communication practices, which may be minimised because they are described as 'small'.

Secondly, existing definitions of compassion suggest that one of its components is the acknowledgement of suffering (see Table 2.5, p.49). The present

research also found that the acknowledgement of suffering, through various affiliative practices, appeared to be an important feature of the ongoing interaction, which participants oriented to. During patient problem-tellings and complaints, ACPs could be held accountable for not displaying affiliation. However, the findings regarding the alleviation of suffering were more circumspect. While the NHS Constitution (2015), and a number of definitions of compassion used in healthcare, incorporate the idea that suffering can be relieved (see Table 2.1, p.17), my data suggests that the alleviation of physical suffering appeared to not always be expected or possible. Interactional evidence was also limited that affiliative practices alleviated suffering. My research suggests that contemporary conceptualisations of compassion, especially when explored interactionally, remain problematic. If compassion involves the acknowledgement of suffering, but the alleviation of suffering can only be assumed rather than proven, there become difficulties distinguishing compassion from concepts such as empathy or sympathy in interaction.

In addition to showing that defining compassion remains complex, the present research also suggests that a binary distinction between compassionate and uncompassionate care may not actually be possible or helpful. As discussed in the literature review, the Francis Report (2010; 2013a) attributed serious failings in care to a lack of compassion. One method to prevent these failings was for healthcare professionals to be instructed in how to provide compassionate care (Francis, 2013a). Other policy proposed that compassion could be measured using traditional patient satisfaction surveys (Department of Health, 2008). The assumption embedded in such policy is that dissatisfaction indicates a lack of compassion. Similar binary assumptions are also evident in research which has developed or used various patient-report or observational scales to measure compassion (Burnell and Agan, 2013; Lown, Muncer and Chadwick, 2015; Lown *et al.*, 2017; Sinclair *et al.*, 2021). These scales imply that compassion is either present or absent in care-giving. Examination of everyday ACP-patient interaction suggests that this simplistic binary distinction is unhelpful. Firstly, nursing practices are not necessarily either *a priori* compassionate nor uncompassionate. In one interaction, an other-initiated repair may support the patient and prevent suffering, while in another a repair initiation may threaten a participant's 'face' and potentially cause suffering. Similarly, mitigation following ACP other-initiated repair does work to minimise any face-threat posed, while in relation to patient's third-party complaints, ACP

responses which mitigate affiliation with the patient's stance potentially limit agreement regarding staff culpability. Secondly, my research suggests that sequences of talk are neither wholly compassionate nor uncompassionate. While an ACP other-initiated repair may cause suffering, through questioning the patient's competence as an interactional partner, the mitigation which was shown to accompany these repair-initiations potentially minimises or limits any possible harm, and therefore displays compassion. If, as proposed, interactional evidence suggests that practices and sequences of talk are neither simplistically 'compassionate' or 'uncompassionate', this raises a number of questions regarding claims that compassion can be measured using observational scales. This finding also raises questions about the shift to values-based healthcare. While this thesis cannot directly answer questions about the shift to values-based healthcare, the research potentially lends credence to claims that values-based healthcare is politically expedient drawing attention away from structural issues in healthcare and locating care failings within the individual (Chaney, 2020; Pedersen and Roelsgaard Obling, 2019; Traynor, 2017).

Previous research reports that healthcare professionals, particularly nurses, feel that they are unable to provide compassionate care in twenty-first century health services (Nijboer and van der Cingel, 2019; Tierney *et al.*, 2017; Barron, Deery and Sloan, 2017). Research exploring enablers and barriers to compassion frequently attribute difficulties with the delivery of compassionate care to factors such as a lack of staff (Brown *et al.*, 2014; Hunter, McCallum and Howes, 2018b; Smith-MacDonald *et al.*, 2019; Straughair, 2019), the separation of care into tasks, and other demands on time such as documentation (Barron, Deery and Sloan, 2017; Brown *et al.*, 2014; Straughair, 2019; Tierney *et al.*, 2017). The present research identifies interactional and institutional demands, which present barriers to the delivery of compassionate care as outlined in policy. In relation to other-initiated repair, for example, I identified both interactional and institutional demands, including the need to obtain accurate information, and restore intersubjectivity and progressivity, which may mean the ACP has to initiate potentially face-threatening repair. While ACPs attempt to mitigate these face-threats by acknowledging responsibility for the loss of intersubjectivity, the need to complete accurate assessments and provide the safest, most effective treatment is prioritised over short-term compassionate responses. I identified similar institutional demands in relation to responses to patient complaints. Analysis showed that affiliation is an accountable response,

which acknowledges patient suffering. However, in contexts where affiliating with a complaint may result in a patient refusing care that could prevent or alleviate suffering, ACPs appear to avoid responses which could be described as compassionate in the immediate interactional context. I suggested that ACPs appear to prioritise safe, effective care that may prevent future suffering, over the short-term compassionate responses described in both policy and healthcare literature.

Previous research identifying barriers to the delivery of compassionate care, tends to recommend that the structural constraints identified need to be addressed, for example, by ensuring adequate staffing (Hunter, McCallum and Howes, 2018b; Smith-MacDonald *et al.*, 2019; Straughair, 2019). These are valid and important arguments but will not, on their own, address problematic contemporary conceptualisations of compassion for healthcare. Although there appears to be a discord between the way nurses navigate the interactional and institutional demands of care delivery and conceptualisations of compassion in policy and previous research, I suggest that the issue may not only be the interactional and institutional demands identified in the present study. Instead, my research suggests that the conceptualisations of compassion outlined in policy and some research, may be incompatible with the interactional and institutional demands of nursing care. As discussed in the literature review, one of the dominant perspectives regarding compassion in policy (Commissioning Board Chief Nursing Officer and DH Chief Nursing Adviser, 2012; Department of Health, 2008; Department of Health, 2015) and some research (Durkin, Gurbutt and Carson, 2019; Graber and Mitcham, 2004; Sinclair *et al.*, 2016a; Straughair, Clarke and Machin, 2019) is that compassion is a value and/or characteristic of the healthcare professional, and that it can be measured through patient satisfaction (Department of Health, 2008; Department of Health, 2013). As other literature identifies, individual healthcare professionals become responsible for both not alleviating suffering and instances where suggested compassionate behaviours are not displayed (Chaney, 2020; Pedersen and Roelsgaard Obling, 2019; Traynor, 2017). If healthcare professionals are providing skilful effective care that prevents or alleviates long-term suffering, but are unable to adhere to the perceived values and characteristics of the 'good nurse' that they have been socialised into, what impact does this have on staff-wellbeing, job satisfaction and retention? The present research cannot show nurses' perceptions of the care delivered in the

recorded interactions, or what impact the discrepancy between the performance of safe, effective care and conceptualisations of compassion in policy had on nurses' wellbeing and sense of work satisfaction. However, further consideration needs to be given to the impact on nurses of a potential dilemma between the actual provision of safe, effective care, which may prevent and alleviate suffering, and policy demands that fail to consider the interactional and institutional context.

8.4 Contribution to practice

Within health services, and nursing particularly, there are major issues with job satisfaction and retention of staff, exacerbated by the context of the Covid-19 pandemic (National Institute for Health and Care Research, 2021). While this study does not claim to be able to address issues that impact on care such as short-staffing and staff wellbeing, it does present two important points which are relevant to these debates. Firstly, the research shows that practices which are often described as 'chatting' (Straughair and Machin, 2021; Fernando *et al.*, 2018; Taylor, Bleiker and Hodgson, 2021) or 'small acts' (Bramley and Matiti, 2014; Graber and Mitcham, 2004; Straughair, Clarke and Machin, 2019) are in fact significant and important to ensuring safe, effective compassionate care. Illuminating these practices helps to show the skill and complexity involved in healthcare communication. Secondly, the research also raises questions about whether more attention should be given to the interactional and institutional dilemmas involved in compassionate interaction. While not dismissing the importance of values in nursing, the increasing pressure to display the generic behaviours, which represent a compassionate nurse according to policy and some healthcare literature, has potential unintended consequences. These possible consequences include pressurising nurses to work in ways which are not contextually sensitive, and could generate feelings of inadequacy and guilt. With foundations in ethnomethodology, the present research does not assume that the practices nurses use are *a priori* representations of compassion. Evidence of not affiliating when someone complains does not necessarily reflect an absence (or presence) of compassion. The interactional practices displayed at these times demonstrate the complex institutional and interactional requirements that nurses are navigating. The present research also therefore raises questions about whether nurses need to be shown and understand the institutional and interactional demands they are navigating. Would training and

explaining these complexities help nurses to understand the reality of the care they are navigating? Certainly, the present study suggests that not empathising or attentively listening are not representative of an absence of compassion. While displaying affiliation and empathy can be taught and encouraged, there also needs to be recognition that there may be good institutional reasons not to affiliate, which are not associated with the characteristics of the nurse. As mentioned above, while not a panacea, acknowledging such issues may go some way to reducing the guilt and self-blame nurses report when unable to deliver the care they desire and which policy and nursing theory suggests is ideal (Barron, Deery and Sloan, 2017; Sinclair *et al.*, 2017b).

A long-term aim of this thesis is to develop training resources to facilitate compassion in nurses and nursing students. Both policy and research have suggested that training is an important component of developing skills for compassionate care. Some studies recommend using reflection and/or patient narratives to understand the patient's experience and develop empathy (Murray and Tuqiri, 2020). There are however, studies which suggest that training in communication skills is an essential part of facilitating compassion in healthcare services (Bessen *et al.*, 2019; Durkin, Gurbutt and Carson, 2019; Kneafsey *et al.*, 2016). Studies recommending training in communication skills often give limited consideration to how such practices occur within their interactional context, referring to generic communication practices such as active listening and positive non-verbal communication (Kneafsey et al., 2016). Findings from this thesis, including the different practices ACPs use to affiliate with patient problem-tellings, and some of the strategies ACPs use to avoid exposing and to mitigate potential face-threats when there is trouble understanding patient's clinically relevant talk, provide evidence from actual practice which can be used in training. However, future training will need careful development. As outlined throughout, the findings presented in this thesis emphasise the contextual nature of the ACPs' responses. As such, any training would need to recognise that the skills presented are not a script for what to do, but a means for increasing awareness about strategies that nurses already use. One method to implement such training is the conversation analytic role-play method (Stokoe,

2014)[41]. Given the questions this thesis raises about current conceptualisations of compassion, consideration also needs to be given to whether training should focus on compassionate communication skills, or the skills that nurses use to manage workplace dilemmas. There is a potential risk that teaching that certain communication practices are compassionate, or focusing on 'small acts', may reinforce some of the current issues with conceptualisations of compassion in nursing. In comparison, training about the sophisticated skill set nurses use to manage competing interactional and institutional demands, potentially prevents the risk of classifying certain practices as displaying the presence or absence of compassionate communication.

8.5 Future directions

While not the first study to use conversation analysis to explore interaction on hospital wards (for example, see Harwood et al, 2018) or nurse-patient interaction (for example, see Benwell and Rhys, 2018; Jones, 2007, 2009; Wu, 2021), it is not an approach frequently used in nursing research, particularly in in-patient settings. This research clearly shows that, even in busy in-patient settings, with staff and patients who are unfamiliar with the approach, collecting audio-visual data is possible. This research therefore shows that there is the potential to explore how many nursing tasks including, for example, medication administration, discharge discussions and assistance with fundamental care[42], are communicated and successfully managed.

Within this conclusion, I have already identified a number of future directions for the present study, including the development of training materials. One of the benefits of addressing future uses of the data during initial ethical approval and

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[41] The conversation analytic role method uses recordings, pausing the recording before the turn of interest and asking trainees how they would respond. Trainees are then shown what actually happened, reflect on this, and consider the consequences of different practices (Stokoe, 2014).

[42] Obviously there are potential issues with collecting audio-visual recordings which may limit or preclude certain forms of data collection e.g. intimate care.

recruitment is that a proportion of the audio-visual data is available for use in future training and research. In addition to developing training materials, there were a number of areas identified during data analysis, which I could not investigate within the scope of this thesis. These include exploring how embodied practices such as touch, particularly during patient problem-tellings, may relate to the enactment of compassion, and recipient design in ACP talk about discharge.

In addition to outlining practices which display compassion, one of this thesis' main contributions is detail regarding how nurses skilfully manage the workplace dilemmas, which competing interactional and institutional demands present staff with. This thesis also suggested that ACPs may be managing competing values during interaction, for example, compassion and safety, and even dignity and compassion. In order to further explicate the tacit knowledge that nurses possess to undertake work that requires the management of these competing demands, further conversation analytic work would be valuable in areas such as interaction during nursing procedures like cannulation or observations, and the negotiation of discharge, especially when independence is decreasing.

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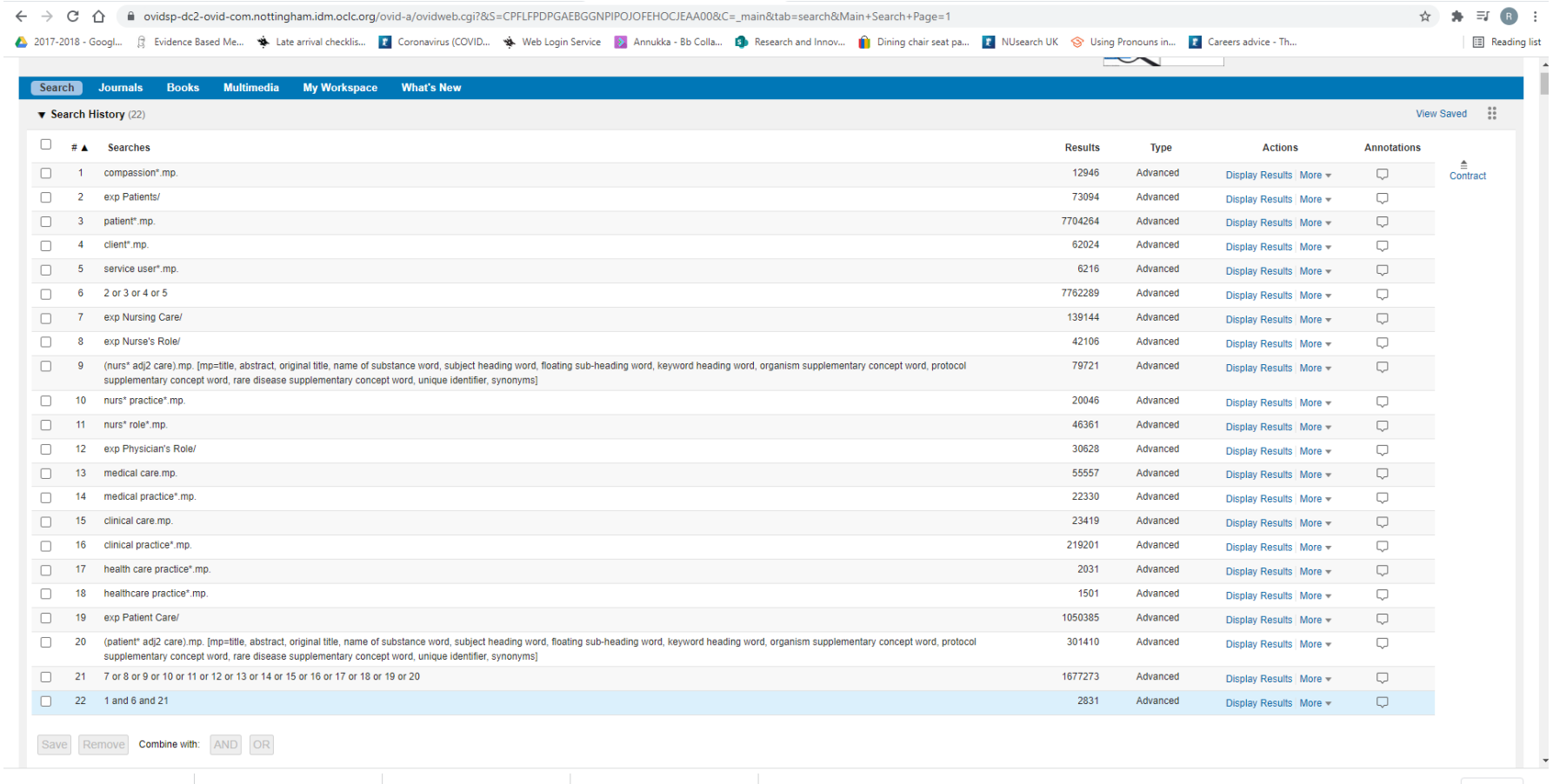
Appendix 1 Search terms for scoping review

	Population	Phenomenon of interest	Context
Concept	Patient	Compassion	Nursing care/health care practice
Synonyms	Health care client Health care service user Health care consumer Health care customer Hospital client Hospital service user Hospital consumer Hospital customer	Compassionate care Dignified care Empathic care Care	Nursing care Nursing practice Nursing role/s Healthcare practice Medical care Physicians care Hospital care Clinical care Clinical practice
Broader terms		Person centred care Care	Healthcare
Related terms		Benevolence Empathy Sympathy Pity Fellow feeling Intelligent kindness Altruism Dignified care Empathic care	
Alternative spellings & variants			Practice Practise
Search terms	Patients (MH) Patient*	Compassion (MH) Compassion*	Nursing care (MH) Nurses role (MH)

	Client* Service user* Hospital customer*		Nurs* adj2 care Nurs* practice* Nurs* role* Physician's role (MH) Medical care Medical practice* Clinical care Clinical practice* Health care practice* Healthcare practice* Patient care (MH) Patient adj2 care
		Adding compassion* care makes no difference	

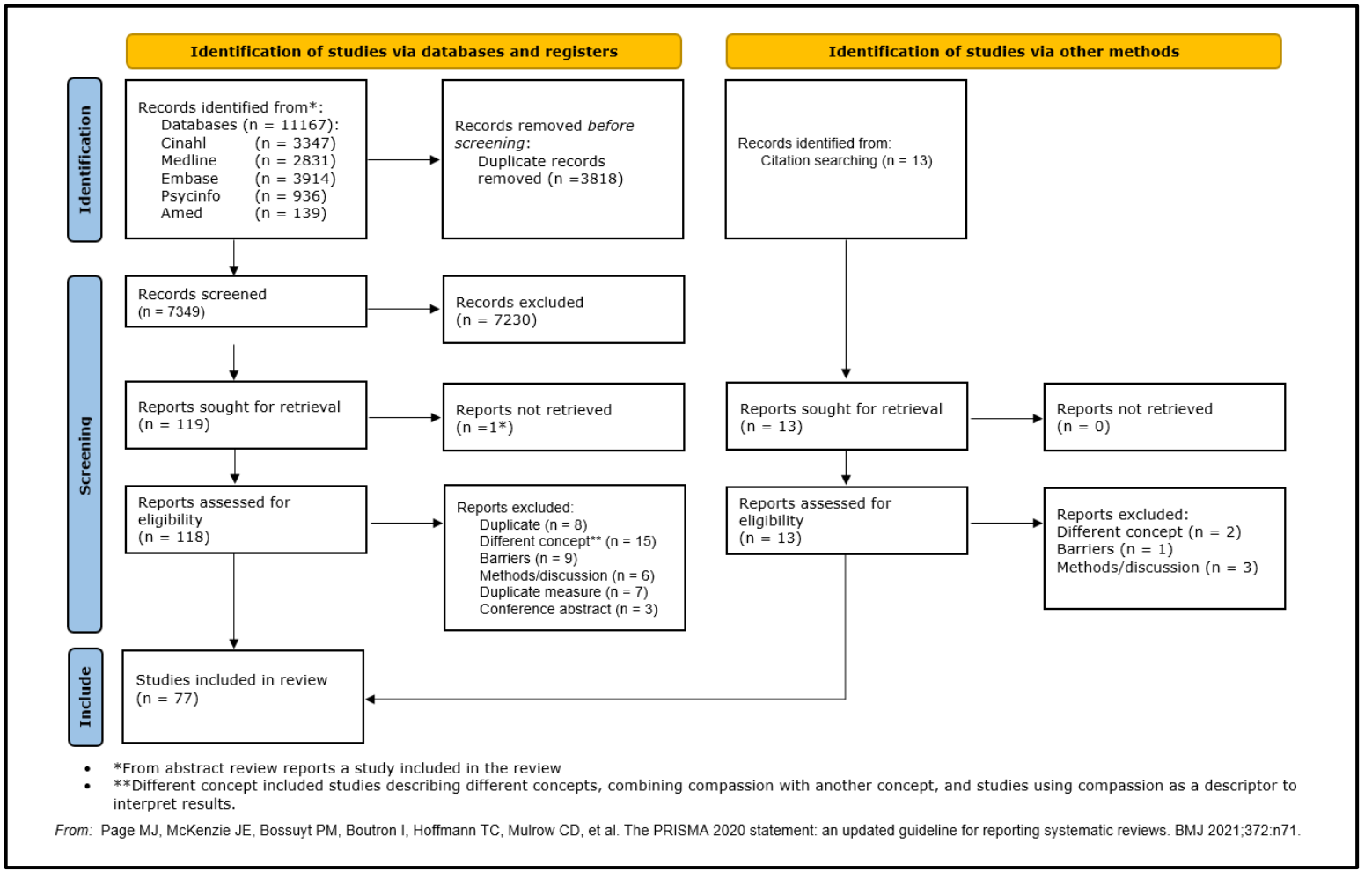
Appendix 2 Medline search (1946 – present)

(Search conducted 19/11/2021)



#	Searches	Results	Type	Actions	Annotations
1	compassion*.mp.	12946	Advanced	Display Results | More	
2	exp Patients/	73094	Advanced	Display Results | More	
3	patient*.mp.	7704264	Advanced	Display Results | More	
4	client*.mp.	62024	Advanced	Display Results | More	
5	service user*.mp.	6216	Advanced	Display Results | More	
6	2 or 3 or 4 or 5	7762289	Advanced	Display Results | More	
7	exp Nursing Care/	139144	Advanced	Display Results | More	
8	exp Nurse's Role/	42106	Advanced	Display Results | More	
9	(nurs* adj2 care).mp. [mp=title, abstract, original title, name of substance word, subject heading word, floating sub-heading word, keyword heading word, organism supplementary concept word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier, synonyms]	79721	Advanced	Display Results | More	
10	nurs* practice*.mp.	20046	Advanced	Display Results | More	
11	nurs* role*.mp.	46361	Advanced	Display Results | More	
12	exp Physician's Role/	30628	Advanced	Display Results | More	
13	medical care.mp.	55557	Advanced	Display Results | More	
14	medical practice*.mp.	22330	Advanced	Display Results | More	
15	clinical care.mp.	23419	Advanced	Display Results | More	
16	clinical practice*.mp.	219201	Advanced	Display Results | More	
17	health care practice*.mp.	2031	Advanced	Display Results | More	
18	healthcare practice*.mp.	1501	Advanced	Display Results | More	
19	exp Patient Care/	1050385	Advanced	Display Results | More	
20	(patient* adj2 care).mp. [mp=title, abstract, original title, name of substance word, subject heading word, floating sub-heading word, keyword heading word, organism supplementary concept word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier, synonyms]	301410	Advanced	Display Results | More	
21	7 or 8 or 9 or 10 or 11 or 12 or 13 or 14 or 15 or 16 or 17 or 18 or 19 or 20	1677273	Advanced	Display Results | More	
22	1 and 6 and 21	2831	Advanced	Display Results | More	

Appendix 3 PRISMA 2020 flow diagram



- *From abstract review reports a study included in the review
- **Different concept included studies describing different concepts, combining compassion with another concept, and studies using compassion as a descriptor to interpret results.

From: Page MJ, McKenzie JE, Bossuyt PM, Boutron I, Hoffmann TC, Mulrow CD, et al. The PRISMA 2020 statement: an updated guideline for reporting systematic reviews. BMJ 2021;372:n71.

Appendix 4 Table of studies included in scoping review that explore or address conceptualisations of compassion

Author, year, country	Research design	Sample	Setting	Aims
Aagard et al. 2018 (USA)	Exploratory cross-sectional study Survey – quantitative & qualitative data[43]	Nurses (n.50)	-	-How US nurses identify, define and display compassion in practice.
Babaei et al. 2016 (Iran)	Qualitative Ethnographic approach	Nurses (n.20) In-patients (n.70)	Medical/surgical wards	-To explore compassionate behaviours of Iranian nurses.
Badger & Royse, 2012 (USA)	Qualitative Focus groups	Burn survivors (n.31)	Burn Survivors Congress	-To understand burn survivors' descriptions of compassionate care.

[43] Aagard et al (2018) report findings from the USA that are included within the international study Papadopoulos et al (2016; 2017).

Baker et al 2018 (Canada)	Critical discourse analysis Corpus grey literature and blogs Semi-structured interviews	Grey literature (n.458) Blog posts (n.247) Interviews (n.9)	Pain clinic Blogs - Canada	-To explore how discourses of compassionate care manifest in relation to evidence based practice.
Barron et al 2017 (UK)	Qualitative Semi-structured interviews	Community mental health nurses (n.9)	Community	-To understand the meaning of compassion for community mental health nurses and the factors that influence their beliefs about compassionate practice.
Bessen et al 2019 (USA)	Qualitative Semi-structured interviews	Physicians (n.13)	Palliative care and oncology	-To explore the methods through which physicians deliver compassionate care at the end-of-life.
Bond et al 2018 (UK)	Corpus-informed discourse analysis	62,626 words	Readers' comments to newspaper and peer-reviewed nursing journals reports on	-To explore how compassion is described and constructed within UK discourse, in response to the recommendation that aspiring nurses gain care experience as a prerequisite to entering nurse education.

			proposal for healthcare experience prior to nurse training	
Bramley & Matiti 2014 (UK)	Qualitative exploratory descriptive study Semi-structured interviews	Hospital in-patients (n.10)	Hospital medical wards	-To understand how patients experience compassion within nursing care and their perceptions of developing compassionate nurses.
Bray et al 2014 (UK)	Mixed methods -Survey -Semi-structured interviews	Healthcare professionals (Survey n.155 Interviews n.7) Pre-registration healthcare students (Survey n.197 Interviews n.7)	University	-Health professionals' and pre-registration students' understanding of compassion and the role of education in fostering compassionate practice.

Brown et al 2014 (UK)	Qualitative Interviews Discourse analysis	Mental health practitioners (n.20)	In-patient mental health unit	-Examine practitioners' accounts of compassion in their daily work. -Explore how practitioners formulated, interpreted and deployed the concept.
Burridge & Foster 2019 (Australia)	Qualitative Focus Group (n.7)	Nurses (n.20)	Hospital (Neurological rehabilitation unit)	-Explore compassion through the perceptions and experiences of rehabilitation nurses.
Cameron et al 2013 (USA)	Qualitative analysis of audio-recordings of consultations (n.49)	Oncologists (n.23) Patients with advanced cancer (n.49)	Oncology clinics	-To develop a taxonomy of compassionate behaviours and statements expressed by the physician that can be discerned by an outside observer.
Crowther et al 2013 (UK)	Qualitative Narrative interviews	Bereaved carers (n.40)	National	-Experiences of people with dementia in the last year of life of compassion from the perspective of their carers.
Curtis et al 2012 (UK)	Qualitative Interviews	Student nurses (n.19)	University – adult nursing programme	-Explore student nurses' experience of socialisation in compassionate practice.

Day 2015 (UK)	Qualitative Written comments	Healthcare staff	Safer care event	-How healthcare professionals define compassion.
Devik et al 2020 (Norway)	Qualitative Secondary analysis of interview narratives	Nurses –(n. 10)	Palliative home care	-Nurses' experiences of compassion when giving palliative care at home.
Dewar & McKay 2010 Dewar & Nolan 2013 (UK)	Action research -Participant observation -Stories -Photo elicitation	Health care staff (n.35) Students Patients (n.10) Families (n.12)	Hospital wards (n.4)	-Explore, develop & articulate strategies that enhance compassion.
Durkin, Gurbett and Carson 2019 (UK)	Qualitative Focus groups Semi-structured interviews	Nurse educators, student nurses, registered nurses and service users (n.34)	University	-Key stakeholders' perspectives of compassion in nursing.

Durkin, Usher and Jackson 2020 (Australia)	Delphi Study	Experts researching compassion[44] (n.9)		-Seek consensus on the characteristics that comprise compassion from researchers in the field.
Durkin et al 2021a (Australia)	Qualitative Interviews – narrative inquiry	Public (hospital care in last 5 years) (n.13) Health professionals (n.11)	Hospital and community	-How compassion is received by patients in a hospital setting and how compassion is expressed by health professionals.
Durkin et al 2021b (Australia)	Qualitative Secondary analysis Interviews – narrative inquiry	Public (hospital care in last 5 years) (n.8) Health professionals (n.4)	Hospital and community	-To investigate and understand how compassion is expressed by nurses and received by patients in a hospital setting. (focus of paper - touch)

[44] Experts from Australia, Netherlands, UK, USA

Efstathiou & Ives 2018 (UK)	Qualitative Secondary analysis of semi-structured interviews	Nurses (n.12)	Intensive care	-How concepts of compassion are framed, utilised and communicated by ICU nurses in the context of treatment withdrawal.
Fernando et al 2018 (New Zealand)	Qualitative Semi-structured interviews	Advanced palliative care patients (n.20)	Hospice	-How palliative care patients perceive, understand and experience compassion from health professionals.
Ferraz et al 2020 (Australia)	Qualitative Semi-structured interviews	Healthcare professionals (n.14)	Palliative care (in-patient & community)	-How health professionals working in palliative care view and understand the construct compassion.
Graber and Mitcham 2004 (USA)	Qualitative Semi-structured interviews	Healthcare professionals (who were noted by peers to be highly compassionate and caring) (n.24)	2 hospitals	-Explore the nature of compassion as practiced by healthcare professionals.

Hammarstrom et al 2020 (Sweden)	Qualitative Secondary analysis of interview narratives	Nurses (n.13)	Forensic psychiatric hospital	-To gain understanding of nurses' compassion in providing forensic psychiatric inpatient care.
Hem & Heggen 2004 (Norway)	Qualitative Ethnography – observation/interviews	Nurses (n.6)	Inpatient mental health ward	-To examine specific nursing practices in the context of compassion.
Hofmeyer et al 2018 (Australia)	Qualitative Typed open-ended questions	Final year nursing students	University	-Nursing students' understanding of compassion and their practices of compassion before and after an online compassion module.
Horsburgh & Ross 2013 (UK)	Qualitative Focus Groups (n.6)	Newly qualified staff nurses (n.42)	Variety of locations	-To explore newly qualified nurses' perceptions of compassionate care.
Hunter 2018 (UK)	Qualitative Semi-structured interviews	Student nurses (who had been on an emergency department placement) (n.15)	University – adult nursing programme	-Explore student nurses' experiences of the provision of compassionate care in the emergency department.

Kneafsey et al 2016 (UK)	Qualitative Focus groups (n.9)	University health & social care staff & students Health & social care staff Public (n.45)	University hospital	-Key stakeholders' conceptions of the term compassion.
Lee & Seomun 2016a (South Korea)	Qualitative Interviews	Nurses	Emergency department ICU Haematology	-To identify the attributes of compassion competence.
Murray & Tuqiri 2020 (Australia)	Qualitative Narrative interviews/storytelling	Nurses Midwives (n.50)	Health district wide	-Understand nurses' and midwives' perspectives of compassionate care.
Newham et al 2019 (UK, Ireland, Canada)	Qualitative Discourse analysis	Nurse educators (n.41)	Universities (n.5)	-To articulate a clearer understanding of compassionate caring via nurse educators' selection and use of published texts and films.

Nijboer & van der Cingel 2019 (Netherlands)	Qualitative Semi-structured interview	Nurses (n.14) < 5 years experience	Hospital and community	-To explore how Dutch novice nurses perceive compassion.
Papadopoulos et al, 2016	Exploratory cross-sectional study Survey – quantitative & qualitative data[45]	Nurses, nurse educators, nurse managers, final year nursing students	-	-To explore similarities and differences between Greek and Greek-Cypriot nurses with regards to perceptions of compassion.
Papadopoulos et al 2016 (International[46])	Exploratory cross-sectional study Survey – quantitative data	Nurses, nurse educators, nurse managers, final year nursing students (n.1323)	-	-To explore nurses views and experiences regarding compassion.
Papadopoulos et al 2017	Exploratory cross-sectional study.	Nurses, nurse educators, nurse	-	-To explore nurses views and experiences regarding compassion.

[45] Data is derived from the international study Papadopoulos et al (2016, 2017)

[46] Australia, Cyprus, Czech, Greece, Hungary, Italy, Israel, Norway, Philippines, Poland, Colombia, Spain, Turkey, UK, USA

	Survey – qualitative data	managers, final year nursing students (n.1323)		
Perry 2009 (Canada)	Qualitative Unstructured interviews Observation	Registered nurses & healthcare assistants (n.7)	Long-term care facility	-To describe the practical actions nurses use to convey compassion to older people.
Roze des Ordons et al 2019 (Canada)	Qualitative Diaries Interviews/focus group	Nurse clinician (n.1) Nurse consultant (n.1) Doctors (n.3)	ICU (n.4) Palliative care services (n.3)	-To understand how clinicians in ICU and palliative care settings perceive expressions of compassion.
Sinclair et al 2016a (Canada)	Qualitative Semi-structured interviews	In-patients (receiving palliative care) (n.53)	Hospital wards inc. palliative care unit	-Palliative cancer patients' understanding and experiences of compassion.
Sinclair et al 2016b (Canada)				-Palliative cancer patients' perspectives on compassion training.

Sinclair et al 2017 (Canada)				-Palliative cancer patient's perspectives, understandings, experiences and preferences of the constructs of 'sympathy', 'empathy' and 'compassion'.
Sinclair 2018a (Canada)	Qualitative Focus groups (n.7) Semi-structured 1:1 interviews	Healthcare professionals (n.57)	Palliative care services	-Healthcare providers' perspectives and experiences of compassion.
Sinclair et al 2018b (Canada)	Qualitative Semi-structured interviews	Non-cancer palliative care patients	Palliative care services	-To assess palliative care model. To understand perceptions and experiences of compassion.
Skorpen et al 2020 (Norway)	Qualitative Focus groups (n.4)	Palliative care nurses (n.21)	Primary care and nursing homes	-Nurses' experiences of compassionate care for patients and families in different phases of palliative care.
Smith McDonald et al 2019 (Canada)	Qualitative Focus groups (n.19)	Long term care residents (n.20)	Long term care facilities	-Perceptions about compassion in the delivery of palliative care from the perspectives of residents in long-term

		Family members (n.16) Healthcare staff (n.72) Managers (n.9)		care, their family members, healthcare staff and managers. -To identify facilitators and barriers.
Straughair et al 2019 (UK)	Qualitative Semi-structured interviews	Members of a service user and carer group[47] (n.11)	University School of Health Sciences	-To explore compassion through the perceptions of individuals with personal experience of nursing care.
Straughair & Machin 2021 (UK)	Qualitative Semi-structured interviews	Nursing students (n.12) Nurse academics (n.8)	University School of Health Sciences	-To advance understanding of compassion from a professional perspective, specifically through the perceptions of student nurses and their educators.

[47] Service users were involved in student nurse curriculum development and sharing stories of care with nursing students.

Su et al, 2020 (China)	Qualitative Semi-structured interviews	Nursing students (with 6 months practice experience) (n.20)	Hospital	-Student nurses definition and characterisation of compassionate care as they participate in clinical practice.
Sundas et al 2020 (Pakistan)	Mixed methods -Exploratory survey -Semi-structured interviews	Nursing students Survey (n.117) Interview (n.17)	Nursing School (n.2)	-Student nurses' understanding of compassion and compassionate care.
Taylor et al 2021 (UK)	Qualitative Secondary analysis[48] Interviews Focus groups	Radiographers (n.112) Student radiographers (n.54) Patients & carers (n.50)	Not stated	-Patients', radiographers' and students' experiences, opinions and beliefs regarding compassion in radiography.

[48] The authors report combining & analysing two studies undertaken about compassion in radiography.

Taylor & Hodgson 2021 (UK)	Qualitative Focus groups (n.11)	Medical radiation technologists (n.27) Student medical radiation technologists (.24) Patients & carers (n.11)	Hospitals (n.3)	-To understand the perspectives of those in receipt and those delivering compassionate practice.
Tehranineshat et al 2019b (Iran)	Qualitative Semi-structured interviews Focus groups (n.2) Observation	20 nurses 8 in-patients 6 family caregivers	Hospital	-Identify and describe compassionate nursing care based on the experiences of nurses, patients, and family caregivers.
Terry et al 2017	Qualitative Discourse analysis[49]	Nurse educators (n.41)	Universities (n.5)	-To articulate a clearer understanding of compassionate caring via nurse educators'

[49] Discourse analysis of participants selected texts/films and questionnaire.

(UK, Ireland, Canada)				selection and use of published texts and films.
Tierney et al 2016 (UK)	Qualitative Semi-structured interviews (n.13) Focus groups (n.4)	Doctors (n.7) Nurses (n.13) Dietician (n.3) Podiatrists (n.6) Health care assistants (n.5) Administrators (n.2) (Total n.36)	-NHS Trusts (n.2) -Diabetes professional networks	-Exploration of views on measuring compassionate care.
Tierney et al 2017 (UK)				-To explore compassion from the perspective of healthcare professionals.
Tierney et al 2018 (UK)	Qualitative Focus groups (n.4)	31 medical students	Medical school	-How students' understanding of compassion to self and others might be shaped by medical training.

van der Cingel 2011 (Netherlands)	Qualitative Semi-structured interviews and observations	Older patients (n.31) Nurses (n.30)	Rehabilitation centre, home care organisation, outpatients clinic	-To understand the benefit of compassion for nursing practice within the context of long-term care.
Way & Tracy 2012 (USA)	Qualitative Observation Interviews	Palliative care patients Healthcare workers	Hospices (n.2)	-To provide a description of hospice workers as they engaged in compassionate communication activities.

Appendix 5 Patient and healthcare professional scales measuring compassion

Study	Measures	Who measures	Definition
Patient Report Measures			
Kret (2011)	Qualities of a compassionate nurse (delivered by nurses)	Individual nurse	None given
Burnell & Agan (2013) Compassionate Care Assessment Tool	-Compassionate care (delivered by trained interviewers)	Nurses	Compassionate care: the patient's need for compassion with the nurse's ability to show concern. Compassionate care is understanding suffering and wanting to do something about it. (p.183)
Lown (2015, 2017)	-Compassionate care	Individual health care practitioner	Recognition, understanding, emotional resonance and empathic concern for another's concerns, distress, pain or

The Schwartz Center Compassionate Care Scale			suffering, coupled with their acknowledgement, motivation and relational action to ameliorate these conditions.
Sinclair et al (2021) Canada Sinclair Compassion Questionnaire	-Compassion	Health care professionals over the last seven days	A virtuous response that seeks to address the suffering and needs of a person through relational understanding and action.
Healthcare Professional Self-report Measures			
Lee and Seomun (2016b) Compassion Competence Scale	-Compassion competence	-	Components of compassion competence: 1.Nurses who have respect for and can empathise with patients based on their professional nursing knowledge. 2.Nurses who can connect and communicate with patients emotionally and with sensitivity and insight, based on their experience and knowledge. 3.Nurses who put constant effort into self-development.

Pommier et al (2020)	-Compassion for self and others	-	Compassion operationalised as experiencing kindness, a sense of common humanity, mindfulness, and lessened indifference to the suffering of others.
Tehranineshat 2021 (Iran)	-Compassionate nursing care	-	Compassionate care is professional care that takes place through clinical excellence, adherence to ethical values, and sensitivity to the needs. Effective interaction through emotional support, building trust and effective communication skills, along with continuous comprehensive care and attention to the patients' existential dimensions, should occur at the same time. (p.5)

Appendix 6 Summary of systematic reviews addressing compassion in healthcare

Author	Review question/s	Key findings
Durkin, Usher and Jackson (2019) Articles reviewed (n.11)	How compassion is expressed by nurses and received by patients in hospital settings?	Virtuous motivation Emotional connection Communication and building understanding Being present Taking action to provide individualised care
Durkin et al (2018) Articles reviewed (n.16)	What are the qualities of a compassionate nurse? How is compassion taught to nursing students? What types of instruments are used to measure compassion in nursing?	Character Connecting to and knowing Awareness of needs/suffering Empathy Communication Body language Involving patients Having time for patients

		Small acts Emotional strength Professionalism Competence
Singh et al (2018) (Articles reviewed n.23)	To identify and describe perspectives, experiences, importance, and impact of compassionate care among ethnically diverse population groups.	Multi-faceted: Motivated by virtues, personal qualities and beliefs in response to another's suffering. Emotional support and physical acts to help the person in need.
Tehranineshat et al (2019a) (Articles reviewed n.46)	What is a comprehensive definition of compassionate care? What are the dimensions of compassionate care in healthcare systems? What are the facilitating and inhibiting factors? What measures should be taken for improving compassionate care in healthcare?	Ethical dimension Professional dimension Efficient communication dimension inc. clinical and informational communication Human-related dimension Religious-spiritual dimension Involving patient dimension

Appendix 7 Findings/themes in research exploring or addressing conceptualisations of compassion

	Character/virtue/disposition	Value	Cannot be learnt (innate)	Can be learnt	Understanding/empathy*	Relational/Connection	Communication/interactive	Holistic/person-centred care	Competent care	Helping/action	Going above & beyond/small things	Comfort	Giving something of self
Aagard et al, 2018						X	X				X		
Babaei et al, 2016					X		X				X		
Badger & Royse, 2012					X		X	X	X		X		
Baker et al, 2018					X			X	X	X			

	Character/virtue/disposition	Value	Cannot be learnt (innate)	Can be learnt	Understanding/empathy*	Relational/Connection	Communication/interactive	Holistic/person-centred care	Competent care	Helping/action	Going above & beyond/small things	Comfort	Giving something of self
Barron et al, 2017		X			X								
Bessen et al, 2019					X		X	X	X				
Bond et al, 2018			X	X									
Bramley & Matiti, 2014	X		X	X	X		X	X			X		
Bray et al 2014		X	X	X	X		X	X	X				
Brown et al, 2014						X	X	X					
Burridge & Foster, 2019		X			X			X			X		
Cameron et al, 2013					X		X	X		X			

	Character/virtue/disposition	Value	Cannot be learnt (innate)	Can be learnt	Understanding/empathy*	Relational/Connection	Communication/interactive	Holistic/person-centred care	Competent care	Helping/action	Going above & beyond/small things	Comfort	Giving something of self
Crowther et al, 2013					X		X				X		
Curtis et al, 2012					X	X	X	X					
Day, 2015			X		X		X						
Devik et al, 2020					X						X	X	
Dewar & MacKay, 2011 Dewar & Nolan 2013					X	X	X	X			X		
Durkin, Gurbett & Carson, 2019	X	X			X		X	X	X		X		
Durkin et al, 2020	X				X		X			X			X

	Character/virtue/disposition	Value	Cannot be learnt (innate)	Can be learnt	Understanding/empathy*	Relational/Connection	Communication/interactive	Holistic/person-centred care	Competent care	Helping/action	Going above & beyond/small things	Comfort	Giving something of self
Durkin et al, 2021a					X	X	X	X	X	X	X	X	
Durkin et al, 2021b						X		X					
Efstathiou & Ives, 2017					X		X	X	X	?	X	X	
Fernando et al, 2018					X	X	X					X	
Ferraz et al, 2020					X	X	X	X		X			
Graber & Mitcham, 2004	X	X				X	X	X			X		X
Hammarstrom et al, 2020					X	X							
Hem & Heggen, 2004		X			X					X			

	Character/virtue/disposition	Value	Cannot be learnt (innate)	Can be learnt	Understanding/empathy*	Relational/Connection	Communication/interactive	Holistic/person-centred care	Competent care	Helping/action	Going above & beyond/small things	Comfort	Giving something of self
Hofmeyer et al, 2018					X			X	X	X			
Horsburgh & Ross, 2013					X			X				X	
Hunter, 2018				X			X				X	X	
Kneafsey et al ,2015		X	X	X	X	X	X	X		X			X
Lee & Seomun, 2016		X		X	X			X	X				
Murray & Tuqiri, 2020					x	X		X		X	X		

	Character/virtue/disposition	Value	Cannot be learnt (innate)	Can be learnt	Understanding/empathy*	Relational/Connection	Communication/interactive	Holistic/person-centred care	Competent care	Helping/action	Going above & beyond/small things	Comfort	Giving something of self
Newham et al, 2019	X				X	X		X				X	X
Nijboer & van der Cingel, 2019	X	X						X			X		
Papadopoulos et al, 2016		X			X	X	X	X		X	X		
Papadopoulos et al, 2016, 2017					X	X	X	X			X		X
Perry, 2009							X	X		X	X		
Roze des Ordons et al, 2019	X		X	X	X	X	X	X			X		
Sinclair et al, 2016a	X				X		X	X			X		
Sinclair et al 2016c	X		X	X	X	X	X	X		X			

	Character/virtue/disposition	Value	Cannot be learnt (innate)	Can be learnt	Understanding/empathy*	Relational/Connection	Communication/interactive	Holistic/person-centred care	Competent care	Helping/action	Going above & beyond/small things	Comfort	Giving something of self
Sinclair et al, 2017	X				X	X					X		
Sinclair et al, 2018a	X		X	X	X	X	X	X	X		X	X	
Sinclair et al, 2018b	X				X	X	X	X		X	X		
Skorpen et al, 2020					X	X	X						
Smith-McDonald et al, 2019	X		X	X	X	X	X	X			X		
Straughair et al, 2019	X		X	X		X	X	X			X		
Straughair & Machin, 2021	X		X		X	X		X			X		

	Character/virtue/disposition	Value	Cannot be learnt (innate)	Can be learnt	Understanding/empathy*	Relational/Connection	Communication/interactive	Holistic/person-centred care	Competent care	Helping/action	Going above & beyond/small things	Comfort	Giving something of self
Su et al, 2020		X	X	X	X			X			X	X	
Sundas et al, 2020	X		X	X	X	X		X	X	X		X	
Taylor et al, 2021				X	X		X	X			X		
Taylor & Hodgson, 2020			X		X	X	X	X					X
Tehranineshat et al 2019b	X	X			X		X	X	X				
Terry et al, 2017					X	X	X			X		X	X
Tierney et al, 2016		X			X	X	X						
Tierney et al, 2017					X	X	X	X					

	Character/virtue/disposition	Value	Cannot be learnt (innate)	Can be learnt	Understanding/empathy*	Relational/Connection	Communication/interactive	Holistic/person-centred care	Competent care	Helping/action	Going above & beyond/small things	Comfort	Giving something of self
Tierney et al, 2018	X	X			X	X	X	X					
Van der Cingel, 2011					X		X			X			
Way & Tracy 2012						X	X			X	X		

*inc. emotional resonance

Key: Patient

Healthcare professional

Patient/Healthcare professional/Public

Experts

Appendix 8 Transcription symbols

(adapted from Jefferson, 2004; Hepburn and Bolden, 2013)

Symbol	Meaning
(0.0)	Indicates time elapsed in tenths of a second
(.)	Indicates a micropause i.e <0.2 sec
[	Indicates the point at which overlapping talk begins
]	Indicates the point at which overlapping talk ends
=	Indicates no break or gap in the talk
.	Indicates a stopping or downward intonation
,	Indicates a continuing or slight rise in intonation
?	Indicates a rising or questioning intonation
word	Indicates some form of stress on the word or sound
::	Indicates an extension of a sound (the more colons the longer the extension)
↑	Indicates a shift into a higher pitch of talk
↓	Indicates a shift into a lower pitch of talk
WORD	Indicates louder speech
◦word◦	Indicates quieter speech
<word>	Indicates speech delivery is slowed down
>word<	Indicates speech delivery is speeded up
.hh	Indicates an in-breath
hh	Indicates an out-breath
£ £	Indicates 'smile voice'
#	Indicates creaky voice

~	Indicates tremulous voice
Huh heh	Indicates laughter
(word)	Indicates transcribed uncertainty/a possible hearing
( )	Indicates transcriber's inability to decipher what was said
(( ))	Indicates transcriber's description of relevant participant action or external phenomenon e.g. another patient calls out.

Appendix 9 Sample Participant Information Sheet for Patients

Participant Information Sheet for Patients

(Final version 1.2: 22nd March 2019)

Title of Study:	**Compassion in Practice: An Audio and Video Based Study with Advanced Clinical Practitioners**
IRAS Project ID:	255858
Name of Chief Investigator:	Dr Alison Edgley
Local Researcher(s):	Rachael Drewery

We would like to invite you to take part in our research study. Before you decide we would like you to understand why the research is being done and what it would involve for you. One of our team will go through the information sheet with you and answer any questions you have. Talk to others about the study if you wish. Ask us if there is anything that is not clear.

What is the purpose of the study?

The purpose of the study is to examine communication between experienced nurses, called advanced clinical practitioners, and patients. We are especially interested in communication that shows care and compassion. We will also examine non-verbal communication such as touch and gestures.

Why have I been invited?

You are being invited to take part because you are a patient at xxxxxxx or on a Health Care of the Older Person ward and you are going to see an advanced clinical practitioner. We are inviting up to 40 participants like you to take part. We hope to record up to 40 consultations in total.

Do I have to take part?

It is up to you to decide whether or not to take part. We will only record a conversation if everybody present, including the nurse, have agreed to take part. If you do decide to take part you will be given this information sheet to

keep and be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time and without giving a reason. This would not affect your legal rights.

What will happen to me if I take part?

If you agree to take part, the consultation with the nurse will be video- or audio-recorded. What happens during your conversation with the nurse will be no different to what would have happened if you were not taking part in the study. The equipment will be set up beforehand so the researcher won't be in the room when you are seeing the nurse.

When you see the advanced clinical practitioner, they will check again that you are comfortable with being recorded. At this stage, or at any stage during the consultation you may ask for the recording to be stopped. The nurse may also stop the recording.

If you agree the researcher will approach you again, at a time convenient to you, to discuss whether we may use the recording for further research and training. This discussion will take approximately 20 minutes and you will have an opportunity to ask questions. If you decide to allow us to use the recording for further research and training the researcher will then ask you to sign a written authorisation form. The authorisation form allows you to tell us who, in addition to members of the research team, may see and/or hear your recording. The authorisation form allows you to decide how we can store and use your video- and/or audio-recording for future research and training purposes. No-one outside the research team will use the recording unless you provide written authorisation at this point. We will only use your recording in the ways that you authorise us to.

At the end of the discussion, the researcher will ask you whether we can approach you again in the future to discuss the possibility of recording another of your consultations with an advanced clinical practitioner while at xxxxxxx or on a health care of the older person ward. If we approach you again in the future, we will ask again for your explicit permission before recording another consultation, and use the same procedures as for the first recording. Even if you have agreed to the recording of one consultation with an advanced clinical practitioner, you don't have to agree to future recordings. We will record up to

three of your consultations with an advanced clinical practitioner. If you prefer not to be approached again, we will respect your wishes and not ask you again.

Why are we recording people seeing the advanced clinical practitioner?

We need to make recordings in order to capture what really happens in communication between advanced clinical practitioners and patients, so that our findings are based on real-life rather than assumptions. We are particularly keen to video-record, because non-verbal communication is so important and video-recording will help us to research how aspects such as touch and gesture are used in communication. We know however, that some people who would like to take part would prefer not to be video-recorded. You can therefore opt to be audio-recorded only if you wish.

Who will see and hear recordings and why?

The research team will see and hear the recordings in order to do their research. We would also like to play clips from some of the recordings to other people. After the recording, we will seek separate optional authorisation to use clips from some recordings in the following ways:

Provided everyone recorded has given permission, we will play clips from some recordings, within closed sessions to other experienced communication researchers outside the University of Nottingham, to improve our understanding.

Provided everyone recorded has given permission, we will play clips in talks about our research to researchers and healthcare staff/students.

Provided everyone recorded has given permission, clips from some recordings may be included in training materials we produce as a result of the findings. Clips will only be shown to trainees during face to face training by professionals who teach communication to health and social care staff and students in the UK.

The clips will be stored on copy-protected disks or drives, kept in the trainers' possession, and/or in a copy protected digital repository – with passwords known only by the trainers and the researchers.

We would like, if you permit it, to use the recordings for research and teaching purposes to enable new research studies to take place aimed at better understanding communication needed for good care.

Finally, if you permit it, we would like to use the recordings in the future for new research studies by the current team and other researchers who may wish to look at aspects other than those we are focusing on in this study.

In the clips we show to other people, we won't disguise any voices or images, but we will blank out person and place names.

Expenses and payments

Participants will not be paid to participate in the study.

What are the possible disadvantages and risks of taking part?

It is possible that the recording process may affect how you and the nurse talk. We will do all that we can to make sure that recording does not disrupt your time with the advanced clinical practitioner. It is however, difficult to know whether or not recording will have an effect. If you feel that the recording is having a detrimental effect, please ask for it to be stopped. The advanced clinical practitioner will do the same.

If you are agreeable for us to play parts of your recording to other researchers, and in talks and/or training, it is possible that someone you know will be there, and that they will recognise you. We will make it clear to all participants that they must not use your name, or discuss your personal details, during or after the meeting. The teachers who use the materials for teaching communication skills will not make copies of the video clips.

What are the possible benefits of taking part?

We cannot promise the study will help you but the information we get from this study may help better understand the communication skills needed for good care and how to use these communication skills for the care of people like you.

What if there is a problem?

If you have a concern about any aspect of this study, you should ask to speak to the researchers who will do their best to answer your questions. The researchers' contact details are given at the end of this information sheet. If you remain unhappy and wish to complain formally, you can do this by contacting:

Name:
Address:
Phone no.:
Email:

In the event that something does go wrong and you are harmed during the research and this is due to someone's negligence then you may have grounds for a legal action for compensation against the University of Nottingham but you may have to pay your legal costs. The normal National Health Service complaints mechanisms will still be available to you.

Will my taking part in the study be kept confidential?

We will follow ethical and legal practice and all information about you will be handled in confidence.

If you join the study, we will use information collected from you during the course of the research. This information will be kept strictly confidential, stored in a secure and locked office, and on a password protected database at the University of Nottingham. Under UK Data Protection laws the University is the Data Controller (legally responsible for the data security) and the Chief Investigator of this study (named above) is the Data Custodian (manages access to the data). This means we are responsible for looking after your information and using it properly. Your rights to access, change or move your information are limited as we need to manage your information in specific ways to comply with certain laws and for the research to be reliable and accurate. To safeguard your rights we will use the minimum personally–identifiable information possible.

You can find out more about how we use your information and to read our privacy notice at:

https://www.nottingham.ac.uk/utilities/privacy.aspx.

The data collected for the study will be looked at and stored by authorised persons from the University of Nottingham who are organising the research. They may also be looked at by authorised people from regulatory organisations to check that the study is being carried out correctly. All will have a duty of confidentiality to you as a research participant and we will do our best to meet this duty.

Where possible information about you which leaves the site will have your name and address removed and a unique code (using your initials) will be used so that you cannot be recognised from it.

Your contact information will be kept by the University of Nottingham for one year after the end of the study so that we are able to contact you about the findings of the study and possible follow-up studies (unless you advise us that you do not wish to be contacted). This information will be kept separately from the research data collected and only those who need to will have access to it. All other data (research data) will be kept securely for 7 years. After this time your data will be disposed of securely. During this time all precautions will be taken by all those involved to maintain your confidentiality, only members of the research team given permission by the data custodian will have access to your personal data.

In accordance with the University of Nottingham's, the Government's and our funders' policies we may share our research data with researchers in other Universities and organisations, including those in other countries, for research in health and social care. Sharing research data is important to allow peer scrutiny, re-use (and therefore avoiding duplication of research) and to understand the bigger picture in particular areas of research. Data sharing in this way is usually anonymised (so that you could not be identified) but if we need to share identifiable information we will seek your consent for this and ensure it is secure. You will be made aware then if the data is to be shared with countries whose data protection laws differ to those of the UK and how we will protect your confidentiality.

Although what you say to us is confidential, should you disclose anything to us which we feel puts you or anyone else at any risk, we may feel it necessary to report this to the appropriate persons.

What happens when the research study stops?

Beyond archiving at the University of Nottingham, we would also like to seek your authorisation so that the recordings may be safely stored in a digital data management archive/repository and used in possible future research for the purposes of teaching and research. This is optional and we would ask you to indicate whether you agree to this on the separate authorisation form.

If you agree to this, the recordings will be stored with a code unique to you in line with current data sharing practices and archived securely and safely at the end of the study in a digital data management archive/repository (e.g.UK Data Archive) under a special licence. Only approved researchers who have obtained the required ethical approvals and permissions will be permitted access to the archived recordings.

Why put information in an archive/repository?

It is impossible for researchers to learn everything they want to from the materials they collect at the time of their study. As so many things can be learned from the materials, preserving them means the materials can be re-used by the same team or shared with other researchers who will be able to do useful research with the materials in the future. Also, it can be very difficult and expensive to recruit participants for research and, once they have contributed, it is important to make full use of their contributions. Finally archives are very good places to keep data safe and secure for the future.

How do I know the information will be used ethically?

Putting materials into an archive is not the same as making them public or making them available on the web. Archivists value materials deposited with them and take their duty very seriously to make sure that the materials are only used in appropriate ways. Their primary concern is to protect research participants.

So that we can archive materials safely, we will anonymise the data we deposit in the archive/repository. This means removing anything that could identify a participant or anyone talked about in the materials, such as names of people and places. In archives, personal contact details are never made available. We cannot fully anonymise the video recordings because doing so would prevent us from adequately researching and teaching about communication. So, to protect research participants, we will also control access to the data in the archive/repository, via licensing. This means that only authorised and registered researchers with specific approval from an NHS Ethics Committee to use the materials for research and teaching purposes will be able to access the materials.

What will happen if I don't want to carry on with the study?

Your participation is voluntary and you are free to withdraw at any time, without giving any reason, and without your legal rights being affected. If you withdraw we will no longer collect any information about you or from you but we will keep the information about you that we have already obtained as we are not allowed to tamper with study records and this information may have already been used in some analyses and may still be used in the final study analyses. To safeguard your rights, we will use the minimum personally-identifiable information possible.

Similarly, should you become unable to give informed consent during the course of the study we would continue to use information already obtained from you. We would not however, make any new recordings without your informed consent or advice from a personal consultee (a friend or relative).

What will happen to the results of the research study?

The results of the study will be written up as part of an educational qualification (PhD) at the University of Nottingham which is due to finish in September 2020. The results will also be discussed at research meetings and written about in research journals. Your personal details will not be given in any publication. If you have given consent for this, images from video-recordings may be used. The results will also be used to help design training materials for health care professionals.

If you and/or your relative would like to receive a summary about what we find, please provide an address (postal and/or e-mail) that we can send this to. These details will remain confidential and will be destroyed after we have sent this summary.

Who is organising and funding the research?

This research is being organised by the University of Nottingham and is being funded as part of a PhD studentship by the Economic and Social Research Council (ESRC) and XXXXX.

Who has reviewed the study?

All research in healthcare is looked at by independent group of people, called a Research Ethics Committee, to protect your interests. This study has been

reviewed and given favourable opinion by Yorkshire & Humber – Bradford Leeds Research Ethics Committee.

Further information and contact details

If you have any additional questions, my contact details are:

Address:

Phone:

Email:

The Chief Investigator Dr Alison Edgley's contact details are:

Address:

Phone:

Email:

Appendix 10 Sample Consent Form – Patient Participants

Consent Form for Patient Participants
(Final version 1.1: 8th March 2019)

Title of Study: **Compassion in Practice: An Audio and Video Based Study with Advanced Clinical Practitioners**

IRAS Project ID: **255858**

Name of Researcher: Dr Alison Edgley (Chief Investigator)
Rachael Drewery

Name of Participant:

Please initial box

1.	I confirm that I have read and understand the information sheet version number 1.2 dated 22/03/2019 for the above study and have had the opportunity to ask questions.	
2.	I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, and without my medical care or legal rights being affected. I understand that should I withdraw then the information collected so far cannot be erased and that this information may still be used in the project analysis.	
3.	I understand that the data collected in the study may be looked at by authorised individuals from the University of Nottingham, the research group and regulatory authorities where it is relevant to my taking part in this study. I give permission for these individuals to have access to these records and to collect, store, analyse and publish information obtained from my participation in this study. I understand that my personal details will be kept confidential.	
4.	I understand that my consultation with an Advanced Clinical Practitioner will be recorded, that the recording may be seen and heard by members of the research team and that anonymous direct quotes from the recording may be used in study reports.	
5.	I agree to the use of the following type of recording in the research: (Please initial A or B) 1. A video-recording of sound and images (i.e. that the research team may collect, store, analyse, listen to, watch, make and read transcripts, and take notes about my consultation) 2. An audio-recording of sound only (i.e. that the research team may collect, store, analyse, listen to a sound recording, make and read transcripts, and take notes about my consultation)	

6.	I understand that I may withdraw consent for any individual recording and that I may vary my authorisations for any individual recording after each recording has been made.	
7.	I agree to take part in the above study.	

_____	_____	_____
Name of Participant	Date	Signature
_____	_____	_____
Name of Person taking consent	Date	Signature

3 copies: 1 for participant, 1 for the project notes and 1 for the medical notes (as appropriate)

Appendix 11 Sample Optional Authorisation

Optional Authorisations for participants
(Final version 1.1: 8th March 2019**)**

Title of Study: Compassion in Practice: An audio and video based study with advanced clinical practitioners

IRAS Project ID: **255858**

Name of Researcher: Dr Alison Edgley
Rachael Drewery

Name of Participant:

Recording No.

Recording Date:

How my recordings can be used for research in this project
Where I have initialled below, I agree to the following use(s) of the recording:
We will only use the recording in the ways you consent to. When we use your recording, your voice and image won't be altered except that we will blank out people and place names.

		Please initial box
A.	**Clips may be played to other researchers** I agree that clips from this recording may be used in closed sessions with other researchers, within and outside the University of Nottingham, to help strengthen the research results.	
B.	**Clips may be played at presentations about the research** I agree that clips from this recording may be used in talks about this research for professional audiences of researchers, health and social care staff and trainees.	
C.	**Stills may be used in published reports about the research** I agree that stills from the video recording may be used in published reports.	

How my recording can be used for research and training beyond this project
We will only use the recording in the ways you consent to. When we use your recording, your voice and image won't be altered except that we will blank out people and place names

Please initial box

D.	**Copy-protected communication skills training videos** I agree that clips from the recording may be used in any communication skills training which is developed as a result of the study. I understand that these will only be shown to restricted audiences during face-to-face training by professionals who teach communication to health and social care staff and trainees.	
E.	**New research by the current research team** I agree that subject to approval, the current research team will have access to the recording for research and teaching purposes beyond the current project.	
F.	**Future research by other researchers** I agree that subject to specific ethical approval, other researchers will have access to the recording for research and teaching purposes beyond the current project.	
G.	**Storage of audio-recordings** In line with current data sharing practices, I agree for my audio recording to be stored securely in a digital data management repository/archive, e.g.UK Data Archive.	
H.	**Storage of video-recordings** In line with current data sharing practices, I agree for my video-recording to be stored securely in a digital data management repository/archive, e.g.UK Data Archive.	

_____	_____	_____
Name of Participant	Date	Signature
_____	_____	_____
Name of Person taking consent	Date	Signature

3 copies: 1 for participant, 1 for the project notes and 1 for medical notes (if patient participant)

Appendix 12 Participant summary booklet for patients

University of Nottingham
UK | CHINA | MALAYSIA

E·S·R·C ECONOMIC & SOCIAL RESEARCH COUNCIL

Participant Summary

(Final version 1.0: 14th December 2018)

Compassion in Practice: An Audio and Video Based Study with Advanced Clinical Practitioners

IRAS Project ID: 255858

Chief Investigator: Dr Alison Edgley
Local Researcher: Rachael Drewery

My name is Rachael Drewery and I will be at [redacted]/Ward ..... undertaking a project about communication between advanced clinical practitioners and patients. We are doing this to better understand the communication skills needed for good care. We will use what we find to develop training for health and social care staff.

This booklet provides information about what the project involves.

You will be seeing an experienced nurse, called an advanced clinical practitioner, as part of your care at [redacted]/ward .....

Before you see the Advanced Clinical Practitioner, we'd like to talk to you about our research and ask you to consider letting us make and use a video- or audio-recording of your consultation for our research.

If, once we have discussed it, you are happy for us to make and use the recording for our research, I will ask you to complete a consent form.

Your decision on whether or not we can record will not affect your care in any way.

Video/audio recording

If you decide to be recorded we will do all we can to avoid any disruption to your care. If we record, the researcher will set up and turn on the equipment, then leave the room while you are seeing the advanced clinical practitioner.

If you require any personal/intimate care while the advanced clinical practitioner is with you the video-recording will be stopped. You can decide whether the audio-recording stays on.

The recording can be stopped at any point if you ask for this. You don't need to give any reason. The advanced clinical practitioner can also ask for it to be stopped.

Afterwards, I will arrange to come and see you to discuss whether we can use the recording for further research and training. This discussion will take about twenty minutes.

At this point, I will discuss the optional details of the study with you, and then ask you to decide who can see and/or hear your recording, and how we may use it in research and in staff communication training.

No one outside of the research team will use the recording unless you provide written authorisation at this point. If you decide not to provide written permission, we will not use the recording for further research and training.

If you are interested in hearing more, please read the accompanying information sheet. If it helps talk to family and friends about the project.

Rachael will come and discuss the project with you and answer any questions that you may have.

For further information, please contact:

Rachael Drewery,
B316
School of Health Sciences,
University of Nottingham,
Nottingham,
NG7 2HA
Tel. [redacted]
E-mail: rachael.drewery@nottingham.ac.uk

The Chief Investigator is:
Dr Alison Edgley,
School of Health Sciences,
University of Nottingham,
Nottingham,
NG7 2HA
Tel. [redacted]
E-mail: [redacted]

Appendix 13 Research Ethics Committee (REC) approval

NHS
Health Research Authority

Yorkshire & The Humber - Bradford Leeds Research Ethics Committee
NHSBT Newcastle Blood Donor Centre
Holland Drive
Newcastle upon Tyne
NE2 4NQ

Telephone: 0207 1048 088

Please note: This is the favourable opinion of the REC only and does not allow you to start your study at NHS sites in England until you receive HRA Approval

22 March 2019
28 March 2019 - Reissue

Dr Alison Edgley
School of Health Sciences, University of Nottingham,

Dear Dr Edgley

Study title:	**Compassion in Practice: An audio and video based study with advanced clinical practitioners**
REC reference:	**19/YH/0012**
Protocol number:	**18077**
IRAS project ID:	**255858**

Thank you for your letter of 14 March 2019, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair.

We plan to publish your research summary wording for the above study on the HRA website, together with your contact details. Publication will be no earlier than three months from the date of this opinion letter. Should you wish to provide a substitute contact point, require further information, or wish to make a request to postpone publication, please contact hra.studyregistration@nhs.net outlining the reasons for your request.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a **favourable** ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

Mental Capacity Act 2005

I confirm that the committee has approved this research project for the purposes of the Mental Capacity Act 2005. The committee is satisfied that the requirements of section 31 of the Act will be met in relation to research carried out as part of this project on, or in relation to, a person who lacks capacity to consent to taking part in the project.

Conditions of the favourable opinion

The REC favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission must be obtained from each host organisation prior to the start of the study at the site concerned.

Management permission should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements. Each NHS organisation must confirm through the signing of agreements and/or other documents that it has given permission for the research to proceed (except where explicitly specified otherwise).

Guidance on applying for HRA and HCRW Approval (England and Wales)/ NHS permission for research is available in the Integrated Research Application System, at www.hra.nhs.uk or at http://www.rdforum.nhs.uk.

Where a NHS organisation's role in the study is limited to identifying and referring potential participants to research sites ("participant identification centre"), guidance should be sought from the R&D office on the information it requires to give permission for this activity.

For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.

Sponsors are not required to notify the Committee of management permissions from host organisations

Registration of Clinical Trials

All clinical trials (defined as the first four categories on the IRAS filter page) must be registered on a publically accessible database within 6 weeks of recruitment of the first participant (for medical device studies, within the timeline determined by the current registration and publication trees).

There is no requirement to separately notify the REC but you should do so at the earliest opportunity e.g. when submitting an amendment. We will audit the registration details as part of the annual progress reporting process.

To ensure transparency in research, we strongly recommend that all research is registered but for non-clinical trials this is not currently mandatory.

If a sponsor wishes to request a deferral for study registration within the required timeframe, they should contact hra.studyregistration@nhs.net. The expectation is that all clinical trials will be registered, however, in exceptional circumstances non registration may be permissible with prior agreement from the HRA. Guidance on where to register is provided on the HRA website.

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

Ethical review of research sites

NHS sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Non-NHS sites

An SSA exemption was submitted which the Committee considered during the review. The Committee decided that the research did not require Site-Specific Assessment at non-NHS sites as it involves no clinical interventions and all study procedures at sites would be undertaken by the Chief Investigator's team. The Committee was satisfied that the risk to participants is likely to be negligible, and the study procedures will not significantly interfere with participants' freedom of action or privacy or be unduly invasive or restrictive.

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	*Version*	*Date*
Copies of advertisement materials for research participants [Patient Poster - ward Compassion in Practice]	1.0	14 December 2018
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Evidence of insurance - Compassion in Practice]	1.0	18 December 2018
IRAS Application Form [IRAS_Form_19122018]		19 December 2018
Letter from sponsor [Letter from Sponsor - Compassion in Practice]	1.0	18 December 2018
Other [ACP Consent form - Compassion in Practice]	1.0	14 December 2018
Other [Accompanying staff Consent form - Compassion in Practice]	1.0	14 December 2018
Other [Companion Consent form - Comapssion in Practice]	1.0	14 December 2018
Other [Summary booklet for Patients Compassion in Practice]	1.0	14 December 2018
Other [Patient poster reenablement unit - Compassion in Practice]	1.0	14 December 2018
Other [Guidance for staff approaching patients - Compassion in Practice]	1.0	14 December 2018
Other [ACP Information sheet - Compassion in Practice]	1.1	08 March 2019
Other [Accompanying staff Information Sheet - Compassion in Practice]	1.1	08 March 2019
Other [Companion Information sheet - Compassion in Practice]	1.1	08 March 2019
Other [Authorisation All participants - Compassion in Practice]	1.1	08 March 2019

Other [Consultee Information sheet - Compassion in Practice]	1.1	08 March 2019
Other [Consultee Advice part 1 Compassion in Practice]	1.1	08 March 2019
Other [Consultee Advice part 2 Compassion in Practice]	1.1	08 March 2019
Participant consent form [Patient Consent form - Compassion in Practice]	1.1	08 March 2019
Participant information sheet (PIS) [Patient Information sheet - Compassion in Practice]	1.1	08 March 2019
Referee's report or other scientific critique report [Scientific Review]	1.0	18 December 2018
Research protocol or project proposal [Protocol Compassion in Practice]	1.1	08 March 2019
Response to Request for Further Information		14 March 2019
Summary CV for Chief Investigator (CI) [CI CV Compassion in Practice]		14 December 2018
Summary CV for student [Student CV]	1.0	14 December 2018
Summary CV for supervisor (student research) [CI CV Compassion in Practice]		14 December 2018
Summary, synopsis or diagram (flowchart) of protocol in non technical language [Study Schematic]	1.0	14 December 2018

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Reporting requirements

The attached document *"After ethical review – guidance for researchers"* gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports
- Notifying the end of the study

The HRA website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

User Feedback

The Health Research Authority is continually striving to provide a high quality service to all applicants and sponsors. You are invited to give your view of the service you have received and the application procedure. If you wish to make your views known please use the feedback form available on the HRA website: http://www.hra.nhs.uk/about-the-hra/governance/quality-assurance/

HRA Learning

We are pleased to welcome researchers and research staff to our HRA Learning Events and online learning opportunities– see details at: https://www.hra.nhs.uk/planning-and-improving-research/learning/

19/YH/0012	**Please quote this number on all correspondence**

With the Committee's best wishes for the success of this project.

Yours sincerely
pp

Sarah Rothera

Dr Janet Holt
Chair

Email: nrescommittee.yorkandhumber-bradfordleeds@nhs.net

Enclosures: "After ethical review – guidance for researchers"

Copy to: *Ms Angela Shone*

Appendix 14 Health Research Authority Approval

Ymchwil Iechyd a Gofal Cymru
Health and Care Research Wales

NHS
Health Research Authority

Dr Alison Edgley
School of Health Sciences,

Email: hra.approval@nhs.net
Research-permissions@wales.nhs.uk

22 March 2019

Dear Dr Edgley

HRA and Health and Care Research Wales (HCRW) Approval Letter

Study title:	**Compassion in Practice: An audio and video based study with advanced clinical practitioners**
IRAS project ID:	**255858**
Protocol number:	**18077**
REC reference:	**19/YH/0012**
Sponsor	**University of Nottingham**

I am pleased to confirm that HRA and Health and Care Research Wales (HCRW) Approval has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications received. You should not expect to receive anything further relating to this application.

How should I continue to work with participating NHS organisations in England and Wales?
You should now provide a copy of this letter to all participating NHS organisations in England and Wales, as well as any documentation that has been updated as a result of the assessment.

Following the arranging of capacity and capability, participating NHS organisations should **formally confirm** their capacity and capability to undertake the study. How this will be confirmed is detailed in the "*summary of assessment*" section towards the end of this letter.

You should provide, if you have not already done so, detailed instructions to each organisation as to how you will notify them that research activities may commence at site following their confirmation of capacity and capability (e.g. provision by you of a 'green light' email, formal notification following a site initiation visit, activities may commence immediately following confirmation by participating organisation, etc.).

It is important that you involve both the research management function (e.g. R&D office) supporting each organisation and the local research team (where there is one) in setting up your study. Contact details of the research management function for each organisation can be accessed here.

How should I work with participating NHS/HSC organisations in Northern Ireland and Scotland?
HRA and HCRW Approval does not apply to NHS/HSC organisations within the devolved administrations of Northern Ireland and Scotland.

If you indicated in your IRAS form that you do have participating organisations in either of these devolved administrations, the final document set and the study wide governance report (including this letter) has been sent to the coordinating centre of each participating nation. You should work with the relevant national coordinating functions to ensure any nation specific checks are complete, and with each site so that they are able to give management permission for the study to begin.

Please see IRAS Help for information on working with NHS/HSC organisations in Northern Ireland and Scotland.

How should I work with participating non-NHS organisations?
HRA and HCRW Approval does not apply to non-NHS organisations. You should work with your non-NHS organisations to obtain local agreement in accordance with their procedures.

What are my notification responsibilities during the study?
The document "*After Ethical Review – guidance for sponsors and investigators*", issued with your REC favourable opinion, gives detailed guidance on reporting expectations for studies, including:

- Registration of research
- Notifying amendments
- Notifying the end of the study

The HRA website also provides guidance on these topics, and is updated in the light of changes in reporting expectations or procedures.

I am a participating NHS organisation in England or Wales. What should I do once I receive this letter?
You should work with the applicant and sponsor to complete any outstanding arrangements so you are able to confirm capacity and capability in line with the information provided in this letter.

The sponsor contact for this application is as follows:

Name: Ms Angela Shone

Email: sponsor@nottingham.ac.uk

Who should I contact for further information?
Please do not hesitate to contact me for assistance with this application. My contact details are below.

Your IRAS project ID is **255858**. Please quote this on all correspondence.

IRAS project ID	255858

Helen Penistone
Assessor

Tel: 0207 104 8010
Email: hra.approval@nhs.net

Copy to: *Ms Angela Shone (sponsor contact)*

Appendix 15 Summary of ethical considerations

Limiting potential disruption & intrusion
• Patient participants initially approached by a member of the care team. Approach acknowledged that this may be a difficult time for patients, and encouraged those experiencing such issues to decline participation. • Study included only patients assessed by the clinical team as being able to participate without causing undue mental or physical stress. • Patients excluded where emergency treatment required or where recruitment may exacerbate stress for the patient. • Researcher checking patient willing to receive information about the study – sensitivity to patient's situation. • Participants given regular opportunities to decline participation – sensitivity to patient's situation. • Researcher a nurse with experience dealing with people in stressful situations. Skills in communicating with patients and reading patient cues. • Researcher ensured the appropriate responsible clinicians was made aware of any need for additional support. • Researcher not present during recording. • Recording equipment positioned as unobtrusively as possible. • Participants informed that if they think recording is impacting the consultation, recording can be stopped. ACPs shown how to stop recording equipment. Aware researcher close by. • Maximum number of recordings per patient 3. • Participants given a choice between audio-visual or audio-only recording. • Recordings part of ACP's usual work/patient's usual care.
Informed consent
• Participants provided with verbal and written information prior to consenting. Patients also given the opportunity to familiarise themselves with equipment prior to recording.

- Written informed consent obtained from participants prior to recording.
- Consent recognised as ongoing and checked throughout all stages of data collection.
- Where a companion or another healthcare professional/student are present during a consultation informed consent to include them in the video-recording.

Confidentiality

- Recordings uploaded onto UoN secure drive following recording, and deleted from cameras.
- Recordings not to be shown to the public or uploaded onto open online locations.
- Participants given choices about who, beyond the research team, can see/hear recordings following the consultation.
- Where participants have granted permission for their recordings to be played to other researchers, in presentations about the research, and /or in teaching:
    i. all these circumstances these will be closed sessions.
    ii. Audience members will be explicitly instructed not to refer to participants by name if they recognise, and not to talk about them in personal or negative terms within or outside the session.
- Recording to occur in single occupied spaces i.e. the patient's bedside/room to minimise the risk of recording other people.
- Patient names visible to the camera covered over prior to recording.
- ACP shown how to pause and obscure the camera lens, in case any intimate care is required.
- Pseudonyms used in transcripts and written reports.
- Names and place names muted out on audio-recordings.
- Use of signs when recording occurred to minimise the risk of others entering.

Appendix 16 Guidance for staff approaching patients about study

Compassion in Practice: An Audio and Video Based Study with Advanced Clinical Practitioners

(Final version 1.0: 14th December 2018)

Guide for staff inviting potential patient participants and relatives/friends to talk to the researcher about the research

• We appreciate many people find this a difficult time and that the most important thing for you right now is getting the help and care you need.

• However, we have a project going on at NUH and Connect House to learn more about how experienced nurses, called advanced clinical practitioners, communicate with patients.

• The research involves recording one of your conversations with the advanced clinical practitioner.

• We are asking some of the patients and their friends and relatives on ward …./at Connect House if they are willing to talk to a researcher to find out more about the project, and see if they would like to take part.

Stop here if they indicate not wanting to see researcher

• Would you consider talking to a researcher today so that you can hear a bit more about the research and see if you might like to take part?

- Introduce to Rachael Drewery, and tell them to expect her to come and find them to have a conversation.
- If you judge the patient and/or relatives and friends are reluctant, please reassure them that they need not participate and it will not affect their care in any way.