A corpus-assisted discourse analysis of
NHS responses to online patient feedback

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Abstract

This thesis reports on aspects of language use and discourse in staff replies to patient feedback posted on the health service review part of the website NHS Choices. The overall aim of the thesis is to contribute to understanding about how NHS staff use language when communicating with patients in a feedback context, and the reasons for the particular linguistic choices they make. The study uses a corpus-assisted discourse studies (CADS) approach to examine linguistic patterns in datasets based on three staff reply text types derived from an 11.5-million-word corpus of NHS replies. The three datasets are 'stock replies' (texts completely or mostly reused in full), 'unique replies' (texts that are likely to have been individually written for one-time use) and 'mixed replies' (texts that consist of a mix of reused and non-reused elements).

This study finds that, while there are linguistic differences between reply types – for example, a greater tendency for those based on text reuse to be more formulaic, and unique replies to entail more variation – these do not predict the interpersonal aspects of replies. Staff replies can be more or less impersonal/personalised irrespective of reply type. In its examination of unique replies, the study highlights a number of patterns contrary to expectations that individualised replies are more personalised, including evidence of indirect criticism and use of discrediting strategies against patients. The latter is a feature of marketised discourse, evidence of which is found across all three reply types. In addition to findings about the language use and discourse of NHS staff, this thesis also presents an original method for using CADS to analyse a corpus containing a high amount of text reuse.

Acknowledgements

Declaration

I hereby declare that this thesis is the product of my own work and has not been submitted in any form for the award of a higher degree elsewhere.

Craig Evans, September 2020

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Chapter 1: Introduction

1.1 Introduction

In response to feedback from patients posted on NHS Choices, a website that allows people to post reviews of health services in the UK, two replies read as follows:[1]

> Thank you for your kind comments and high ratings. We are glad that you feel you have been cared for in an informative and efficient manner. We look forward to seeing you again in due course. (20 September 2013)

> Many thanks, and we think we know who the nurse with a "lively character" is. :-) We are super happy that you have felt we genuinely care - because we do. Feedback like yours makes it all worthwhile. (20 May 2015)

These responses were written by National Health Service (NHS) staff, the publicly funded healthcare system that operates in the UK. Both are replies to positive feedback and both contain a similar number of words, but in other respects they represent distinctly different ways of responding to feedback. For example, the first reply is written in a careful, managerial style. It includes references to management performance using formal evaluative wording ('an informative and efficient manner', 'high ratings'), and the final sentence suggests the conventional closing of a business letter, with the vague, non-committal expression 'due course' producing a perfunctory effect.

In contrast, the second reply is more conversational. After an initial slightly formal expression of gratitude, 'Many thanks', the author responds to a detail in the feedback without any preamble – 'we think we know who the nurse with a "lively character" is' – which is suggestive of a conversational turn. The use of scare quotes here, when combined with the smiley emoticon, seems ironic, perhaps intended to express light-hearted knowingness. Other features of everyday talk in the second reply include the colloquial intensifier 'super', and the fragment 'because we do', which functions like an interjection and creates the effect of an unplanned expression of emotion.

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[1] All examples from the data presented in this thesis are reproduced with the original orthography.

The contrast between these two examples suggests that NHS staff have different ideas about how to communicate with patients or that they have different purposes when responding to feedback. The linguistic choices of staff may reflect these different purposes and ideas, or there might be other reasons for the particular language used. As just two replies from the tens of thousands produced by staff across the NHS, the above examples may be representative of a variation that is characteristic of replies to feedback. On the other hand, one or both could be typical or atypical of a way of responding to feedback that is generally consistent. All of this illustrates the problem that I propose to address in this thesis: how to make sense of the different ways that healthcare staff use language to respond to online feedback.

Further details of the aim of this thesis are provided in the next section (Section 1.2). The remainder of the chapter is then structured as follows. Section 1.3 will provide a definition of the term 'discourse', which represents the main focus of this study. Section 1.4 will present an account of the origin of the thesis topic, which includes details of a pre-existing project to which this PhD study is linked, and information about factors influencing the topic choice. Then, Section 1.5 will present an overview of key themes, which includes a brief review of relevant literature. This section is divided into three subsections, each of which corresponds to a different theme.

Building on the discussion of previous research in Section 1.5, Section 1.6 will explain the rationale for the present research focus. This will be followed by Section 1.7, which sets out my research questions. Section 1.7 is divided into three subsections which provide commentary about the rationale and scope of the research questions, and details of how and where they are addressed in the thesis. The chapter ends with Section 1.8, which outlines the structure of the thesis.

1.2 General aims of the thesis

An overarching aim of this thesis is to contribute to knowledge about how healthcare workers use language to communicate with patients in the context of responding to their feedback. More specifically, the thesis aims to discover the ways the use of language by health service staff produces different interpersonal effects, and how this is influenced by certain discourses and discourse functions. To this end, it examines staff replies to comments about individual

services posted on the Review section of the website NHS Choices between March 2013 and September 2015.[2]

A purpose of healthcare review websites like NHS Choices is to encourage patients to share accounts of their healthcare experiences, and in this respect they represent a means for staff to engage with patients. Given this, a further aim of the thesis is to discover ways in which replies to feedback provide evidence of staff drawing on discursive resources that encourage patient engagement. The thesis also investigates reasons for instances where staff may *not* use replies to feedback as an opportunity to engage with patients. By highlighting discursive resources that encourage patient engagement and identifying factors that affect the use of such resources, the thesis proposes to produce findings that could be of practical use to NHS staff to help them improve the quality of replies and, therefore, the experience of patients.

1.3 Definition of 'discourse'

This thesis uses a corpus-assisted discourse studies (CADS) approach, the main focus of which is the analysis of discourse. CADS variously combines elements from corpus linguistics and discourse analysis. Details of the theories and methods pertinent to these two approaches, as well as information about how they are combined in CADS, are included in Chapters 2 and 3. For the purpose of providing an overview of the main object of focus in this thesis, namely discourse, this section will provide a definition of the term 'discourse' in relation to how it is used in this study.

Two meanings of 'discourse' are used in this thesis. The first refers to how socially situated language use performs different interpersonal and meaning-making functions. Widdowson (2004) represents this sense of discourse as 'the pragmatic process of meaning negotiation' (p. 8), which also fits with Brown and Yule's (1983) general definition of discourse as 'language in use' (p. 1). Discourse as language in use is subject to context-specific influences, such as the established linguistic and social practices associated with a particular communicative situation. Discourse in this sense could also be used interchangeably with the term 'register', which refers to text varieties produced when certain 'linguistic features'

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[2] The NHS Choices website is at www.nhs.uk. Since this study was undertaken, the patient feedback and staff responses have been removed from the site.

correspond with particular 'communicative purposes' (Biber and Conrad, 2009). An example of a particular register is when salespeople use hyper-polite linguistic forms and a personalised style for the purpose of persuading people to buy their goods or services – this might be identified as a customer service register or discourse.

The second definition of 'discourse' used in this thesis is based around Foucault's (1969) view of 'practices that systematically form the *objects* of which they speak' (pp. 135–40 and 49). This differs from the first definition in that the primary focus is not on how language use serves a particular socio-communicative purpose in a given context, but on how the use of particular words, narratives, metaphors and so on can represent different ways of viewing the world. Such representations can reflect the values and beliefs of a person or group, and in this way discourse is sometimes viewed as related to ideology (Baker, 2010). For example, a racist ideology or discourse would be evident when othering language is used to represent people, based on race, in ways that are disparaging and harmful. This close association between discourse and ideology is explained by Fairclough (1985) when, in the process of defining ideology, he observes that 'the relationship between proposition and fact is not transparent, but mediated by representational activity' (p. 754).

The two definitions of discourse presented here are not mutually exclusive. How someone uses language to perform local interactional functions, for example, is often likely to be influenced by and to reflect wider discursive norms. As noted by Jaworski and Coupland (2006):

> Discourse is implicated in expressing people's points of view and value systems, many of which are 'pre-structured' in terms of what is 'normal' or 'appropriate' in particular social and institutional settings. Discourse practices can therefore be seen as the deployment of, and indeed sometimes as acts of resistance to, dominant ideologies. (pp. 5–6)

In this thesis, the two meanings of discourse identified in this section will be used both separately and in combination depending on what emerges from the findings over the course of the analysis.

1.4 Background

The study reported in this thesis examines the language of people who work for the NHS. The NHS is a publicly funded health system, paid for by British tax revenue, which provides services across the spectrum of different healthcare needs – for example, general health check-ups, dentistry and hospital care – that are free for all at the point of delivery. It is available for people whose primary residence is the UK, with some services also available to non-residents, such as emergency care. As the flagship of the welfare reforms of the 1940s, the NHS has become an important symbol of national pride and identity. However, it has also been the focus of considerable ongoing debate, particularly between people calling for NHS reform and those suspicious of surreptitious attempts to privatise the NHS.

This thesis is linked to an Economic and Social Research Council (ESRC)-funded project carried out by members of the Corpus Approaches to Social Science (CASS) research team at Lancaster University. The project, titled 'Beyond the Checkbox', involved CASS researchers using corpus-based discourse analysis to analyse patient feedback from the website NHS Choices. The aim of this analysis was to help the NHS gain a better understanding of the feedback.

For this purpose, the project team created a 29-million-word corpus of patient comments which had been posted on NHS Choices between 2013 and 2015. Members of CASS and the NHS then worked together to devise questions to ask of the data. These included questions about which issues were considered most important to patients and the factors most likely to produce positive and negative feedback, among others. (For further details about the findings from this project see Baker, Brookes and Evans, 2019.)

The PhD project reported in this thesis is based on a studentship offered by CASS on the proviso that it continue to use corpus-based discourse analysis on the NHS Choices data provided by the NHS. In addition to the patient feedback data, the NHS Choices website contained 11.7 million words of staff replies to that feedback, which were also downloaded and converted into a corpus, with replies linked to the original patient comments. This staff replies corpus forms the primary focus of this thesis. This focus was partly motivated by the fact that staff replies had not previously been analysed, as the 'Beyond the Checkbox' project had, up to that point, only been concerned with patient feedback. However, the main reason

for my choice to focus on staff replies was the fact that this data was pertinent to several socially relevant issues that have been receiving media attention in recent years.

One issue that has attracted news interest is concern about the effects of the behaviour of NHS receptionists, as illustrated by the following headlines: 'Abrupt GP receptionists are suspected of filling up A&E' (*The Times*, 2016) and 'Receptionists "put people off seeing doctor"' (*BBC News*, 2016b). The first of these stories refers to research led by Elizabeth Stokoe at Loughborough University (Stokoe, Sikveland and Symonds, 2016) and observes that calls prematurely ended by GP receptionists may be driving patients to visit A&E if they feel their local GP practice cannot help them. The second story is based on a Cancer Research UK survey and observes that receptionists 'quizzing patients about why they need to see their GP' (*BBC News*, 2016b) may be putting people off seeing a doctor when they need to.

These news stories suggest that the behaviour of receptionists may lead to pressure on NHS services and a danger to the well-being of individual patients. Communication and use of language are key factors in determining this behaviour, which therefore provides grounds for linguistic research of healthcare discourse in non-clinical contexts. In this way, the focus on staff replies in this thesis helps contribute new findings to related previous research such as that conducted by Stokoe, Sikveland and Symonds (2016).

Another issue that highlights the social relevance of researching the practice of online healthcare reviews is NHS marketisation. The launch of NHS Choices in 2007 was announced by a news article with the headline 'Patients to post "customer reviews" of the NHS online' (*The Daily Mail*, 2007). With no critical treatment of this characterisation in the article itself, this unquestioning description of NHS reviews as 'customer reviews' implies that all online service reviewing represents a commercial activity. In this way, a question arises of whether NHS Choices promotes marketisation in the NHS.

This is a particularly sensitive issue in the context of ongoing debates and controversies relating to the NHS being opened up to markets, as exemplified by the headline, 'Hospital trusts accused of "backdoor privatisation"' (*The Guardian*, 2018a), which related to NHS Hospital Trusts setting up private companies. However, marketisation is not only reflected by NHS reorganisation activities. In an article titled 'The NHS will fail us so long as we look on it as a market' (*The Guardian*, 2013), former *New Statesman* editor Peter Wilby discusses

how treating the NHS as a commercial enterprise creates 'impossible expectations', which means that the NHS will always be seen as a failing institution. In this way, marketisation is as much about how the public think about the NHS as it is about any tangible organisational changes.

A strong motivation for this study of discourse on a healthcare review website, then, is the potential role the practice of online service reviewing may have in encouraging NHS marketisation. In this study, evidence for whether this is the case with NHS Choices will be considered by examining how language is used on the website, specifically that of healthcare staff whose language is the focus of this thesis.

1.5 Overview of key themes

1.5.1 Patient-centred care

When then-Health Secretary Patricia Hewitt announced the launch of NHS Choices in April 2007, her announcement included the following statement:

> We are determined to put patients at the heart of the NHS, and making sure patients can access and share information about health services is a crucial part of that. (*Nursing in Practice*, 2007)

The notion of putting patients 'at the heart of the NHS' is also known as 'patient-centred care', a principle that is widely applied in a number of health services around the world (Kitson et al., 2012). Based on Hewitt's statement, facilitating patient-centred care can be viewed as a primary purpose of NHS Choices. Therefore, in a thesis that examines the language use of NHS staff on this website, patient-centred care represents an important theme.

The concept of patient-centredness can be interpreted in a variety of ways. For example, it can refer to engagement with patients' personal histories beyond medical concerns or to the promotion of collaborative relationships between patients and clinicians (Coulter, 2013). There is debate about what patient-centred care means in practice (Kitson et al., 2012), but typically it is represented as a communication issue which requires healthcare staff to 'listen

carefully to' and be 'willing to discuss personal or emotional issues' with patients (Coulter, 2013, p. 9). One purpose of this kind of communication is that it is likely to help patients feel cared for, but it may also have medical value when the illness stories of patients are a source of 'clinically salient information' (Charon, 2006, p. 191).

In the NHS, government spending policies and restricted budgets can mean that patient-centred care represents more of an ideal than an implementable practice. For example, news stories from recent years include the following headlines: 'NHS suffering worst ever staff and cash crisis, figures show' (*The Guardian*, 2018b) and '"Patients at risk" from length of GP consultations' (*BBC News*, 2016a). The lack of human and financial resources in the NHS reported in the first of these stories is a causal factor of the situation described in the second; that is, a pressure on GPs to 'carry out complex consultations in 10 minutes or under' (*BBC News*, 2016a). In this context, the holistic approach to healthcare represented by patient-centred care may not be a feasible proposition for many in the NHS.

Communication is a key element of patient-centred care, yet there are time constraints on providing this in clinical situations, indicating the potential importance of communication in non-clinical healthcare spaces in helping to provide patient-centred care. This will be considered in the present study with respect to how healthcare staff use language on the website NHS Choices.

1.5.2 Discourse, patient-centred care and personalisation

As well as the shortfalls of human and financial resources impeding the provision of patient-centred care, the ability of health service staff to provide more individualised healthcare can also be affected by a lack of discursive resources. The opportunity and willingness of staff to discuss non-clinical issues with patients is not sufficient on its own to produce patient-centred care. This is because how people engage with each other is often discursively mediated, especially in institutional contexts. Therefore, research on the way discourse practices produce different relational effects has an important role to play in contributing to an understanding of how patient-centred care can be achieved.

The relational implications of discourse in health settings are suggested in Stokoe, Sikveland and Symonds (2016), which explores the link between patient satisfaction and how GP

receptionists use language with patients over the phone. Using conversation analysis (CA), the study highlights how conversational features such as unmet patient requests at the start of calls create what the authors describe as a 'burden' on patients (2016, p. 780). This study finds that CA evidence of different levels of 'burden' at several GP practices is linked to patient satisfaction rates for the same practices: the higher the 'burden', the lower the patient satisfaction. This shows that the discursive choices of GP receptionists influence how patients feel about healthcare staff and the service they provide.

Other research on discourse has focused specifically on patient-centred care. This includes a critical discourse analysis (CDA) of dietitian notes (Lovestam et al., 2015), which addresses patient-centred care as a matter of linguistic representation and identifies how the routine use of agentless passives and nominalisation minimises patients' participatory role. Another study (Koenig et al., 2014) uses CA to examine the conversations between doctors and diabetic patients when doctors are recommending treatment changes. This study focuses on how doctors employ different communication techniques to negotiate between the medical interests and personal preferences of patients.

In both of these studies, the meaning of patient-centred care is specific to the scenarios in question. In the former, patient-centred care is about representation, based on the fact that language can be more or less person-centred. In the latter, it is an issue that arises through a particular dilemma in which patients' medical interests do not necessarily align with their personal interests. However, patient-centred care has the potential to be ubiquitous in the language used by healthcare staff, in the sense that language can be used in a personalised way that encourages patients to feel individually engaged. In the context of an under-resourced NHS, as described above, how much patients feel cared for and listened to may be the primary means of creating a patient-centred experience. In this respect, another way to consider discursive evidence for patient-centred care is more generally in relation to linguistic personalisation.

A number of studies have identified how linguistic personalisation is used for different audience engagement purposes (Knupsky and Nagy-Bell, 2011; Ginns, Martin and Marsh, 2013; Childs and Walsh, 2017). These include a study on feedback on student essays which compared written with spoken feedback, and highlighted the benefits of the personalisation associated with the latter; for example, the way that greater use of second-person pronouns,

hedges and more words to explain technical terms supports greater engagement (Gardner, 2004). Another study (Childs and Walsh, 2017) reports on police interviews with child witnesses of alleged sexual offences and identifies how police officers used personalisation strategies such as self-disclosure and self-deprecating behaviour to encourage witnesses to trust them. Personalisation strategies are also observed in Ginns, Martin and Marsh (2013), which reports on how personalising reading materials for learning purposes – for example, by replacing third- with first- and second-person pronouns, and adding direct-addressing sentences and more politeness forms – helps improve reader-retention. Such studies highlight the important relational dimension to language use in certain situations, which this thesis will argue is an essential element of healthcare discourse.

While previous studies highlight specific discursive features indicating the presence or absence of personalisation – for example, second-person pronouns, agentless passives or nominalisations (see above) – these features are not used as the basis for a systematic analysis of personalisation in the present study. Instead, personalisation is treated as a phenomenon that needs to be analysed in context. This allows for consideration of a potentially broad range of features, including unexpected ones, and of how the combined occurrence of these may affect the degree to which language use can be analysed as personalised. Context-specific factors can also provide insights about whether language is likely to be experienced as personalised, regardless of what features may or may not be present. For example, in the context of a formal complaint being made, a conversational response may seem tactless and produce an impersonal effect. In this thesis, the loss of systematicity due to not basing the analysis of personalisation on specific discursive features at the outset is offset by the principle-based corpus linguistic methods used instead.

In addition to studies that address how language is personalised in particular texts and interactional situations, previous research has also considered the way discursive personalisation represents a wider social phenomenon. Fairclough (1994) uses the term 'conversationalisation' to refer to the blurring of boundaries between public and private as colloquial features are increasingly adopted in public service discourse. This arguably represents evidence of greater cultural democratisation, as might also be observed in the health service in the shift away from traditional paternalistic relationships based on the unquestioned authority of doctors (Brown, Elston and Gabe, 2015; Brashers et al., 2000). However, the democratising credentials of conversationalisation can be challenged by the

argument that it may provide a more subtle, disguised means by which people can use their position of power to exploit others (Fairclough, 1994).

The idea that conversationalisation is a deliberate discursive strategy and not just a social trend is represented by the term 'synthetic personalisation' (Fairclough, 1993). This highlights the sense in which personalised language use can represent an artificial construct, such as when the language in texts intended for a mass audience is written in a style that suggests it is addressing an individual. Synthetic personalisation has long been a feature of promotional discourses, such as advertising, where it has been used for persuasive purposes. In more recent years, the use of such persuasive strategies has increasingly become a feature of language use in public service domains. This will be discussed in the next subsection.

1.5.3 Marketisation of public service discourse

Marketised discourse describes features of language use in public service contexts that are traditionally associated with commercial and corporate contexts. This topic has particularly been the focus of research looking at universities (Fairclough, 1993; Mautner, 2005), and, more recently, in relation to healthcare (Hunt, Koteyko and Gunter, 2015; Brookes and Harvey, 2016), although the marketisation of healthcare discourse still remains an under-researched topic. The relevance of discursive marketisation to the present research is suggested by the situation of the data; that is, the online review of NHS services, which is strongly associated with commercial contexts, such as reviews of hotel services on websites like TripAdvisor.

Evidence of marketised discourse is produced when 'elements of advertising and other promotional genres' occur in public service discourse (Fairclough, 1993, p. 146). When comparing traditional and modern university job adverts, Fairclough highlights the influence of two genres in particular: a 'commodity advertising genre' and a 'genre of prestige or corporate advertising' (Fairclough, 1993, p. 146). Features of the first include persuasive techniques that help 'sell' a public service; for example, the use of statistics and cited external sources to support claims of positive self-evaluation (Benwell and Stokoe, 2006). The second includes features such as the discursive construction of an institutional identity that is 'personalised and assertive' (Fairclough, 1993, p. 146), for example when corporate-*we* is used with self-promotional language.

Discursive marketisation can be linked to a campaign of institutional marketisation in public services that has been occurring in the UK since the 1980s. Cameron (2000) notes that, in the NHS, a tax-funded 'internal market' was created 'in a deliberate effort to simulate features of market capitalism that were thought to make it more efficient than the welfare state' (p. 14). With the passing of the 2012 Health and Social Care Act, which includes a 'competitive clause' that encourages GP commissioners to purchase from both the NHS and private companies (Brookes and Harvey, 2016, p. 290), these simulated features have become actual market practice.

Marketised healthcare discourse is not simply an effect of political action to open up the NHS to market; rather, both discursive and institutional changes reflect the influence of a culture of enterprise. Enterprise culture refers to values and behaviours, such as 'resourcefulness, self-discipline, openness to risk and change', and other attributes like having a strong customer focus, characteristic of the corporate world, which have spread to the public sector (Cameron, 2000, p. 14). In some respects, the influence of enterprise culture can be attributed to the adoption of new market-based management models for the purpose of modernising public services (O'Reilly and Reed, 2011). However, this influence is not limited to internal institutional practices, as illustrated by the managerial language (in italics) used in self-management literature provided by the NHS as part of the Expert Patients Programme (EPP), as described in Veinot (2010):

> expert patients must *act upon* symptoms, make *effective* use of medication, *manage* work, access leisure activities and *develop strategies* to deal with the psychological consequences of their illness. (p. 38)

This example demonstrates an expectation that enterprise values should govern the behaviour of individuals. However, the representation of uncertain and unpredictable illness as something 'amenable to managerial intervention' is problematic as it is at odds with the fact that aspects of a person's illness can be beyond their control (Veinot, 2010, p. 39). This representation suggests a neoliberal perspective of healthcare, one closely associated with the language of enterprise, where 'accountability for health [is] devolved from the government to the level of the self-governing, responsible and enterprising individual' (Hunt and Koteyko, 2015, p. 446).

Neoliberal views inherent in marketised healthcare discourse warrant critical consideration in the context of publicly funded health services like the NHS, particularly where these views run contrary to the collectivist principles on which the NHS was founded. Many studies on discourse marketisation employ a CDA approach (e.g. Fairclough, 1993; Brookes and Harvey, 2016). CDA refers to a set of methodologies for analysing discourse that take an overtly critical stance based on a perceived social problem associated with a situation of language use, which has been identified at the outset of a study (see Wodak and Meyer, 2009, for a comprehensive account of different CDA approaches). The social problem represented by marketised healthcare discourse is that it promotes commercial norms in a public service context. This may help support arguments for NHS privatisation, and a potential future situation where healthcare in the UK ceases to be universal. While a CDA approach is not used in the present study, where evidence emerges to support a critical point, this will be highlighted.

In this thesis, the term 'marketised discourse' is primarily used to refer to evidence in NHS staff language use of values, norms and practices associated with commercial and corporate contexts. Occasionally, I also use the term 'corporate discourse' to refer to the same kind of evidence, but where the discursive features examined specifically relate to the projection of a corporate identity, similar to what Fairclough identifies as the 'genre of prestige' (see above). Corporate discourse is a type of marketised discourse, so use of the term in this thesis is not intended to distinguish separate discourses, but to foreground the sense in which some marketised features are characteristically corporate.

1.6 Rationale for the present study

A primary reason for studying replies to online patient feedback is that, to my knowledge, no previous linguistics research has addressed this practice. This gap in the literature merits filling because responding to feedback is a widespread activity involving staff across the NHS. Therefore, an account of what employees of a publicly funded service are doing when they reply to feedback is warranted, and this is evidenced by how they use language.

However, beyond filling a gap in research, there is a stronger motivation for studying staff replies, which is the fact that they have an important role to play in the practice of collecting patient feedback. How staff respond to feedback might reflect elements of the value or

purpose of patient feedback. For example, a short, cursory reply to an account of a patient's detailed personal experience might suggest the feedback has little importance to healthcare staff. In this way, studying staff replies may help contribute to research and understanding about patient feedback.

From a linguistics point of view, my personal interest in staff replies lies with the link between patient feedback and the notion of patient-centred care, which suggests that replies to feedback have a relational function in which language may play an important role. Therefore, the language of replies represents a window on the relational work that staff might be expected to engage in when interacting with patients in the context of collecting feedback, an activity that arguably serves a patient-centred care purpose. This provides an opportunity to explore the interpersonal function of language use in a non-clinical healthcare context, where there has been limited previous research.

Related to the expectation that the language of staff replies to feedback will provide evidence of relational work is the potential for a study of such language to produce findings that may be useful to NHS managers interested in service quality improvement. For example, an analysis of word choices or grammar can reveal different ways that social actors (e.g. healthcare staff and patients who have provided feedback) are positioned in relation to each other. How linguistic choices position staff and patients, and the different potential relational implications of these, could be useful for informing NHS policy on how staff should respond to feedback.

A final motivation for this study is my interest in discourse marketisation in public service contexts. As observed in Section 1.5.3, a precedence for online reviews of services has been established in relation to commercial enterprises, such as hotels. This suggests that the language of staff replies may provide some evidence of marketised healthcare discourse. Such a finding would help contribute to the limited existing research on this discourse, and given the expectation to find such evidence in this language use context, to find no such evidence would in itself be interesting.

1.7 Research questions

1.7.1 List of research questions

To achieve the general aims stated in Section 1.2, this thesis will address the following overarching research question: *How do NHS staff use language to respond to online patient feedback, and why do they use it in this way?* In pursuit of an answer to this question, and in light of the social relevance of the topic and rationale for the study described in Sections 1.4 and 1.6, respectively, several specific research questions have been formulated which are listed below. The reasons for this choice of questions and their scope in terms of what they propose to answer are detailed in the subsection that follows.

RQ1.   What factors, such as type of feedback (whether positive or negative) and provider type, influence different uses of language?

RQ2.   How do linguistic choices position staff, patients and the relationship between them, and how does this relate to the concept of patient-centred care?

RQ3.   How does staff use of language reflect different discourses in terms of (a) register and (b) ways of viewing the world, and how do these relate to patient-centred care?

RQ4.   How can corpus-assisted discourse analysis be used on data consisting of a large amount of reused text?

1.7.2 Rationale and scope of the research questions

The first research question, RQ1, reflects the fact that the staff replies data is linked to metadata which represents specific contextual information about individual reply texts. This includes the type of service provider that produced the reply (GP practice, dentist, etc.); it also includes information about ratings of services (when these occur) that were provided by patients with the original feedback (see Section 4.3). This information is potentially useful for highlighting any links that may exist between identified language patterns and type of service provider or type of feedback based on whether feedback is positive or negative. RQ1, then, is

intended to make use of the metadata, which represents quantifiable contextual information, in order to provide an account of how these factors influence the language of replies.

The next two research questions, RQ2 and RQ3, represent the thesis's main research questions, and focus on the language use and discourse evident in staff replies to feedback. They call for a descriptive analysis of the language of replies, but both questions also include a second part asking how the first part relates to 'patient-centred care'; this potentially provides scope for the analysis to include some critical evaluation (i.e. in the sense that the language of replies may have a negative effect on patient-centred care).

The rationale for RQ2 is that it addresses the thesis aims to consider the interpersonal effects of staff language use when they respond to feedback, and to discover in staff replies evidence of discursive resources being used for patient engagement purposes (see Section 1.2). It does this by focusing on linguistic choices and their potential to position social actors in ways that can produce different relational effects. The interpretation of these effects will be informed by existing research on the relationship between language and social meaning (see Section 2.4).

The rationale for RQ3 is that it addresses another part of the thesis aims; that is, to investigate the reasons why staff might not use language in a way that is likely to encourage engagement, as might be expected given the principle of patient-centred care that pervades the NHS and is identifiable with the activity of collecting feedback. The two types of discourse identified, register and ways of viewing the world (see Section 1.3 for definitions), both represent possible reasons why staff might use language in ways that are different to what is expected. This is because both types of discourse can be associated with norms and practices that may override the local interpersonal goals of staff language use. Generally speaking, RQ1, RQ2 and RQ3 also all address the overarching research question about *how* staff use language when responding to feedback, and *why* they use it the way they do.

The final research question, RQ4, is a methodological question necessitated by the discovery of a high volume of duplicate and part-duplicate texts in the staff replies data. As CADS is the main approach used in this thesis (see Section 1.3), and given an absence in the literature of previous CADS research that addresses the problems created by text reuse in corpus-assisted studies (see Chapter 3), a new CADS method is required. In this way, RQ4

represents a question that requires answering before all the other research questions in this thesis can be addressed.

1.7.3 Where and how the research questions are addressed

RQ2 and RQ3 are primarily addressed by Chapters 5 to 7 of the thesis. Each of these chapters is dedicated to a separate dataset that has been derived from the staff replies corpus and represents a different reply type (see Chapter 3 for details about these datasets). In the first instance, statistically based methods are used on the datasets to identify patterns that are representative of the language use of each reply type, such as a keyword analysis (as used in Chapters 6 and 7).

From the statistically based linguistic patterns initially generated using corpus methods, salient features are identified for closer analysis. Features judged salient are those that help address RQ2 and RQ3, such as those that are relevant to the relational aspects of language use or that represent the presence of particular discourses. This approach is also used on sample texts selected for qualitative analysis, as occurs in particular in Chapters 5 and 7. To address the second parts of RQ2 and RQ3, evidence of patient-centred care is considered on an ad hoc basis as part of this analysis.

The other two research questions, RQ1 and RQ4, are addressed in Chapters 4 and 3, respectively. Chapter 4 presents a quantitative analysis of how metadata links to the three reply type datasets that are individually analysed in Chapters 5 to 7. In so doing, this chapter addresses RQ1. Finally, RQ4 is addressed in Chapter 3, which provides details of the method, as well as how it was developed, for using CADS to analyse a corpus containing a high volume of reused text. RQ4 is also answered by Chapters 4 to 7 which exemplify the use of the method in practice.

1.8 Organisation of the thesis

This thesis is organised as follows. Chapter 2 will present a review of literature that builds on the overview of previous research in Section 1.5. This will include a general review of health communication research, and a more focused review of literature on the aspects of patient feedback that are most relevant to this study; that is, the purpose of patient feedback and

replies to feedback. The review will then discuss previous research on the relational aspects of language use in health contexts, a primary theme in this study, including politeness, before moving on to discuss theory and concepts relating to the main method used in this thesis, corpus-assisted discourse analysis (CADS). The final review section of Chapter 2 will discuss previous research on corpus approaches to text reuse.

In Chapter 3, the particular CADS method used in this thesis will be presented. This chapter will include an overview of the data and details about how the 11.5-million-word staff replies corpus was divided into three datasets based on reply type as a way of addressing the problem of text reuse. Chapter 3 will also outline the general methods of analysis used on the datasets. However, the nature of CADS as an approach that often needs to be adapted to emergent findings means that specific details of methods used are included as part of the main analysis chapters (Chapters 5 to 7).

The next four chapters are analysis chapters, starting with Chapter 4 which will present quantitative findings on the link between metadata and each of the three datasets examined in this thesis. As an analysis of metadata, this chapter develops the data overview included in Chapter 3 while providing an introduction to each of the datasets that will be examined in turn in the three main analysis chapters that follow. These datasets consist of reply types, which include stock replies that will be analysed in Chapter 5, unique replies that will be analysed in Chapter 6 and mixed replies that will be analysed in Chapter 7.

The three main analysis chapters share some general similarities in the way they are organised: they will each start with an analysis of linguistic patterns identified using statistically based corpus procedures, before moving on to a closer analysis of salient features or text samples. However, the different nature of each dataset entails the use of tailored methods, which means that they differ in the particular ways they are organised. Specific details of the ways in which Chapters 5 to 7 are organised, as with all of the chapters in this thesis, are provided in the introductions at the start of each chapter.

The final chapter, Chapter 8, will present a conclusion which reflects on the study's findings and how the research questions have been addressed in the thesis. This chapter will also consider the strengths and limitations of the study, the potential impact of findings and avenues for further research.

Chapter 2: Literature Review

2.1 Introduction

This chapter presents a review of previous research for the purpose of contextualising the present study in relation to the field, explaining key theory and highlighting any gaps in the literature. The review starts, in Section 2.2, with an overview of research on health communication, which is divided into four main topic areas and discusses literature and themes from these areas that are most relevant to the research presented in this thesis.

Literature relating to the specific focus of my thesis, responses to patient feedback, is then reviewed in Section 2.3. This section is divided into two subsections. The first (Section 2.3.1) discusses research that helps shed light on the purpose of patient feedback, and therefore, by implication, the purpose of replies; the second (Section 2.3.2) reviews key studies that specifically examine replies to online feedback. This is followed by Section 2.4, which presents a review of literature that addresses a primary theme of this thesis, the relational aspects of the language of healthcare professionals; this is addressed in Section 2.4.1, and then developed with a focus on the topic of politeness in Section 2.4.2.

Section 2.5 reviews previous research relevant to the general method used in this study, namely the combination of corpus linguistics and discourse analysis. This is divided into four subsections. The first two, Sections 2.5.1 and 2.5.2, provide an overview of corpus linguistics and discourse, respectively. Section 2.5.3 then discusses the rationale for combining these methods, and Section 2.5.4 reviews literature relating to how a combined corpus linguistic and discourse analysis method is used in practice.

A main feature of this study that has emerged from the extensive text reuse found in the staff replies data is the issue of how to analyse a corpus containing large amounts of text reuse. Therefore, Section 2.6 reviews previous corpus linguistic studies relating to text reuse. Finally, Section 2.7 briefly summarises the chapter.

2.2 Overview of health communication research

Communication, in particular the use of language, plays a central role in healthcare provision and how people experience and understand different health-related matters. Health communication represents a broad area of research which is reflected by the existence of several academic journals[3] and books dedicated to the topic (e.g. Brown et al., 2006; Harvey and Koteyko, 2012; Hamilton and Chou, 2014). A review of these reveals that health communication consists of a great complexity of themes and issues, to which the books cited here provide a useful introduction. For the purposes of the overview presented in this section, research relevant to the present study will be considered, focusing on the following four topics: interactions between patients and healthcare personnel, communication as an organisational issue, public health information and communicating health and illness experiences.

In research on interactions between patients and healthcare workers, the focus has mostly been on doctor–patient consultations, where researchers have been interested in identifying typologies of the structure of consultations (Byrne and Long, 1976; ten Have, 1989) and addressing the way power imbalances are enacted through such encounters (Fairclough, 2001; Harvey and Koteyko, 2012). The method typically used in studies on doctor–patient interaction is conversation analysis (CA), which involves analysing the sequential patterns of transcribed talk-in-interaction and the social actions represented by such patterns (Drew et al., 2001). CA studies on doctor–patient interaction have tended to address one or more of the following specific issues: how institutional talk encourages patient compliance with prescribed treatments (Lutfey, 2004; Crawford et al., 2004); the role of interactional techniques in carrying out diagnoses (Ekberg and Reuber, 2016); and interactional management (Deppermann and Spranz-Fogasy, 2011).

Research that addresses the last of these issues, interactional management, has been especially concerned with the interpersonal dimension of doctor–patient interactions, and the relationship between the medical focus of doctors and the personal focus of patients (Coupland et al., 1994; Greenhalgh and Hurwitz, 1998). Mishler (1984) distinguishes

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[3] Examples include the *Journal of Health Communication* (editor: Scott Ratzan) (www.tandfonline.com/toc/uhcm20/current) and *Health Communication* (editor: Teresa Thompson) (www.tandfonline.com/toc/hhth20/current).

between the 'voice of medicine' used by doctors and the 'voice of the lifeworld' used by patients (p. 14), while Coupland et al. (1994) highlights how patients and doctors collaborate in switching talk between socio-relational and medical frames. Non-medical talk also includes small talk in doctor–patient consultations, and can serve the interpersonal function of 'ignoring or effacing certain kinds of agonistic relations' that may be created when doctors perform physical examinations or take notes (Maynard and Hudak, 2008, p. 685).

In studies on doctor–patient interactions, the relational aspects of such interactions have mostly been addressed in terms of how these support clinical objectives. However, some studies have also explored the varied nature of patients' encounters with healthcare staff in a number of roles, which has helped to highlight staff interest in patients' well-being beyond any medical conditions. For example, in contrasting the communicative styles of doctors and nurses, Harvey and Koteyko (2012) observe that:

> the more open structures apparent in the nurse-patient exchange reflect the emphasis
> in nursing on patient-centred and holistic care, an approach to medicine which
> recognises the importance of patients' psycho-social needs just as much as their
> physical needs. (p. 47)

The interpersonal dimension of healthcare encounters has also been addressed in research on patients' interaction with non-clinical staff. This includes studies that have identified the rapport-building role of GP receptionists (Hewitt et al., 2009) and linked their behaviour to patient satisfaction (Stokoe et al., 2016 – see Section 1.5.2 above for details), and a study on patients' interactions with healthcare personnel at a call centre (Manuti et al., 2013). The relational aspects of healthcare interactions have also been examined with respect to online health communication. For example, Locher and Hoffman (2006, discussed in Harvey and Koteyko, 2012, pp. 191–5) reports on a health advice website. Here, responses to people's queries were provided by a team of advisors using a persona named 'Lucy', which was discursively constructed using a combination of interpersonal and advice-giving strategies.

In addition to its role in healthcare delivery at an interactional level, health communication has been the focus of research on a number of other organisational activities. This includes studies on specific communicative practices such as producing and maintaining patient medical records (Hewett et al., 2009; Swinglehurst, Roberts and Greenhalgh, 2011;

Swinglehurst and Roberts, 2014; Harvey and Koteyko, 2012), interpreter services (Leanza, 2005; Angelelli, 2014) and incident reporting, as may be required of clinicians when patients have come to harm in their care (Iedema, 2005, 2014).

A theme that recurs across a number of these studies is the relationship between institutional and personal discourses. In literature on incident reporting, this relationship takes the form of discursive tensions between personal sentiments and organisational norms (Iedema, 2005). In research on patient medical records, a more suppressive situation between organisational and personal priorities is revealed, one involving several institutional linguistic practices that depersonalise and objectify patients (Harvey and Koteyko, 2012). These include the use of passive voice so that patients are not always explicitly represented in their medical records, technical terminology to represent patients as symptoms or categories rather than people and account markers (e.g. 'claim', 'note') that emphasise the subjectivity of patients' accounts and suggest scepticism (Harvey and Koteyko, 2012).

Studies on health communication concerned with organisational issues also include research on communication skills training (Blatt et al., 2014; Tsai et al., 2014; Brown et al., 2006) and workplace interactions between healthcare staff (Villagran and Baldwin, 2014; Schryer et al., 2007; Maseide, 2007; Iedema and Merrick, 2016). Communication skills training refers to a variety of pedagogical approaches that draw on research of the kind identified above in relation to patient–provider interaction. With medical students, an aspect of communication that receives particular attention in training is the use of 'open questions' in order to elicit a full account of patients' medical needs (Tsai et al., 2014).

Research on workplace interactions addresses communication between staff who work in the same team and inter-professional communication. For example, Iedema and Merrick (2016) investigates team communication in relation to the interactive practice of the clinical handover, such as when doctors pass on notes about patients to other doctors taking over at the end of their shift. Interaction between different kinds of health professionals is the focus of Schryer et al. (2007). This study analyses written correspondence between healthcare workers in similar roles, optometrists and ophthalmologists, and identifies the important relational role of language in such interactions, observing that 'modality both reflects and helps to negotiate interdisciplinary boundaries and competing claims to authority and resources' (p. 473).

So far, this section has provided an overview of research on the role of communication in the delivery of healthcare. Health communication also concerns practices outside the day-to-day activities of healthcare professionals, such as the transmission of health information. This has been a major focus in previous research, which includes general literature on the use of persuasive communication techniques for public health promotion purposes (Berry, 2007). Other studies examine specific text types, such as the patient information leaflet, where language has been found to be ambiguous, for example through the use of 'frequency descriptors ("rarely", "seldom", "occasionally", etc.)' in information about drug side effects (Harvey and Koteyko, 2012, p. 161). Research on communicating health information has also focused on particular public health education campaigns, such as those relating to smoking (Brown et al., 2006) and practising safe sex (Jones, 2014).

Research on the communication of health information is not limited to state-supported public health education activities. Other sources of health information include the internet, particularly via the use of social media, and traditional news media outlets. As a means for transmitting health information, social media has been positively characterised as low cost, collaborative and wide-reaching (Prestin and Chou, 2014). However, critical studies have highlighted how health information transmitted via social media can reflect the commercial, neoliberal values of companies that run and use such sites (Hunt and Koteyko, 2015). The ease with which social media can be used as a platform to influence the public regarding health matters has also made it a focus of research on health misinformation. A study on anti-vaccination information on Facebook identifies the strong use of emotion, sentimentality and experiential knowledge instead of scientific evidence in texts about vaccinations (Ma and Stahl, 2017).

Literature on the representation of health issues in the news has also tended to take a critical view (Koteyko et al., 2008; Brookes et al., 2018; Monaghan, Rich and Bombak, 2019; Atanasova et al., 2019). This includes a study that identifies the tendency for the UK press to represent people with dementia 'in disembodied form, devoid of mind' in a way that reduces their human identity, while observing that the disease itself is represented as powerful and having agency (Brookes et al., 2018, p. 389). In another study, information in newspapers about MRSA is shown to be framed in particular ways, usually in terms of defence or blame, that reflect the political agendas of newspapers and quoted politicians, rather than focusing on the science behind MRSA (Koteyko et al., 2008).

Research on the transmission of health information has often been concerned with health knowledge being communicated between authoritative sources (or sources perceived as such) and the general public. More recently, an aspect of health communication that has increasingly been of interest to researchers is health knowledge based on people's experiences of health and illness. From a healthcare perspective, this may reflect the shift from a biomedical view of patients to an approach to healthcare that '[pays] attention to lived experiences of illness … of what patients say and endure so that they can be fully grasped by those listening and witnessing' (Charon, 2006, p. 192).

Interest in health experiences is evident in a growing body of research that addresses 'the issue of how these experiences, be they articulated in stories, brief quotes, images, or numbers, are constructed' (Mazanderani and Powell, 2013, p. 98). This includes studies on how the experience of cancer is constructed through metaphor (Semino and Demjen, 2017; Semino et al., 2017), a study on how patients use narrative positioning as a coping strategy (Lucius-Hoene et al., 2012) and a sociolinguistic study that looks at the way variables like gender, age and social class influence how people talk about illness (Charteris-Black and Seale, 2010).

Studies on health communication address not only how language represents a means by which patients construct their experience of illness, but also how language can construct illness, specifically with respect to mental health conditions. This has been observed in the way in which talking about feeling 'depressed' reflects how the experience of unhappiness is a fact of life, whereas when people talk about 'depression' they construct their experiences as a clinical condition (Harvey, 2012). In some cases, language is part of the illness itself, as with voice-hearing by people experiencing psychosis. Recent research has proposed that linguistic approaches to power and control may contribute to understanding of the lived experiences of people with such conditions (Demjen et al., 2017).

A considerable proportion of research on how health and illness experiences are communicated has focused in particular on patient feedback. This topic is addressed in the next section.

2.3 Patient feedback and replies to feedback

2.3.1 The purpose of patient feedback and online healthcare reviews

This subsection discusses the purpose of patient feedback in order to provide context and possible explanations for the motives of healthcare workers when they respond to feedback. Patient feedback can be summed up as information relating to patients' experiences of health services which is elicited via particular institutional mechanisms. The primary mechanism traditionally used has been surveys, designed to gather information about patient satisfaction for the purpose of evaluating 'some overall sense of contentment with services' (Graham and Woods, 2013). Survey results indicating dissatisfaction can highlight the need for improvements, and therefore provide a trigger for intervention. The justification for satisfaction rates being used as a measure of improvement needs is provided by evidence that satisfaction is a predictor of health outcomes (Fitzpatrick, 1991).

Since the 1980s, patient feedback has moved from rating satisfaction – a concept that has been criticised as 'broad and often ill-defined' (Coulter et al., 2009, p. 7) – to focusing more on patient experience (Cleary, 1998; Graham and Woods, 2013). This has implied a change in the purpose of patient feedback from indicating the need for service improvements to providing an important resource for identifying what, where, for whom and how urgently improvements are needed. It has also entailed a change in the methods used to collect feedback, with ideal surveys represented as containing questions that elicit specific information about patients' experiences (e.g. 'Were you given information about any side effects of your medicine?') rather than general satisfaction categories (Coulter, 2006, p. 1). The focus on patient experience has also led to feedback being collected via a variety of means, such as focus groups, in-depth interviews and patient diaries (see Coulter et al., 2009, p. 14, for a comprehensive list).

While the purpose of patient feedback in theory may be to provide a resource to help improve services, this is not necessarily achieved in practice. Systematic reviews of patient feedback studies have highlighted the absence of evidence of feedback influencing staff performance (Evans et al., 2007) and a lack of theoretical frameworks to explain the link between feedback and behavioural change (Cheraghi-Sohi and Bower, 2008). Sheard et al. (2017) identifies several conditions needed for the implementation of patient feedback in hospitals.

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These are staff having the autonomy and resources to act on feedback, the cooperation of other departments and the belief of staff that 'listening to patients is a worthwhile exercise' (p. 19). With respect to this last condition, a number of reasons have been suggested for staff resistance to using patient feedback, including the view that staff are able to hear patient concerns when they regularly see them in person (Cleary, 1999), and the attitude that patient feedback is unrepresentative, inexpert and therefore not credible (Asprey et al., 2013; Adams, Maben and Robert, 2018).

If feedback does not lead to improvement in the quality of patient care, this raises questions about its purpose. One possibility is that it represents a self-contained management exercise, where collecting feedback demonstrates listening to patients, and ostensibly serves the purpose of 'giving patients a voice' without actually affecting services. A managerially oriented use of patient feedback might well lead to improvements in the 'hotel aspects' of health services, such as catering and physical accessibility, which managers have control over, but not in the more clinical aspects of healthcare (Fitzpatrick, 1991, p. 887).

Little evidence has been identified for how patient feedback leads to quality improvements in healthcare (Reinders et al., 2011; Gleeson et al., 2016; Baldie et al., 2018); however, improving care still represents a primary motivation for collecting feedback, as argued by Coulter et al. (2014). This is also suggested by the attention given to the issue in a recent National Institute for Health Research report, *Improving Care by Using Patient Feedback*, which notes that 'A lot of resource and energy goes into collecting feedback data but less into analysing it in ways that can lead to change' (National Institute for Health Research, 2019, p. 3). In this respect, while patient feedback might not lead to healthcare improvements, as an aspiration this still appears to represent its primary purpose.

So far, this subsection has reviewed research that is mostly concerned with traditional methods of patient feedback (e.g. surveys). This means that evidence of the purpose of feedback tends to reflect the perspective of health institutions. When feedback is unsolicited, as is the case when it is posted on a healthcare review website, the motivation of patients has been more of a concern for researchers. Baker, Brookes and Evans (2019) identifies several reasons for patients providing online feedback (adapted from the 11 motivations for people posting consumer reviews online in Hennig-Thurau et al., 2004). These include: to help a health service provider or other patients, such as by providing them with experience-based

information they might act on; to feel empowered, as may occur when people present themselves as expert-patients or use the public platform of review websites in a retaliatory way against staff; to initiate contact to provide an entry point into 'more meaningful interaction' (p. 14); and to vent negative feelings or enjoy the feel-good effects of praising.

Most of these identified reasons for posting feedback online can also be linked to the overriding purpose of wanting to engage a public audience, as indicated by evidence of language strategies used to encourage reader involvement. For example, research on online consumer reviews has highlighted how imperatives and second-person pronouns are used to engage readers through direct address, while the use of discourse markers – posing questions to the reader and implying their role as an interactional partner (e.g. 'Wait! There's more…') – helps create the effect of a simulated conversation (Vasquez, 2014, p. 97). Language strategies have also been observed in online reviews produced by patients, such as when first- and second-person pronouns are used to personalise and generalise, respectively, for the purpose of reader engagement (Baker, Brookes and Evans, 2019).

The evidence of persuasive language being used in online reviews supports the view that some of the motives for writing reviews concern the exercise of power. This is a justified motive with consumer reviews, where positive feedback has been linked to increased sales (Vasquez, 2014), which can be attributed to greater trust in peers than company brands (Pedersen, Razmerita and Colleoni, 2014). In the case of public services, where bad publicity presents less of an existential threat, the power of disreputation is still effective when there is the perception that this may harm an organisation. In the healthcare setting in the UK, this perception may be encouraged by the increased tendency for the NHS to be viewed in business terms (Sturgeon, 2014; Brookes and Harvey, 2016).

The remainder of this subsection will discuss the purpose of online healthcare reviews from a critical perspective. While patients may have particular goals when they post or read reviews about health services, the reason for such practice can also be explained by ideological factors; for example, the ideology represented by the view of patients as empowered institutional actors who have a role to play in the management of health services. As the author of one study on healthcare review websites observes: 'As part of a health system, patients are expected to be more active – managers – not only in their own care, but as levers in the governance of healthcare providers' (Adams, 2011, p. 1070). This idea that the practice

of online patient feedback places a greater onus on patients to help manage health services is potentially problematic should it lead to too much of a reduction in the responsibility of health professionals.

The emphasis on individual responsibility, one that entails a neoliberal view of healthcare, has been criticised in previous research. This includes a study on midwifery which highlights problems with interpretations of the concept of informed choice, when empowered patients are viewed as autonomous actors not in need of the care and support of staff (Spoel, 2010). Other research highlights how excessive individual accountability for healthcare risks compromising patients' well-being. For example, one study observes, with respect to the self-management of people with chronic illnesses, that patients may feel they are to blame when they have failed to manage an illness beyond their control (Veinot, 2010, p. 39). The practice of posting and reading patient feedback online may not lead directly to the kind of adverse effects of neoliberalism represented by these studies, but it still may encourage the kind of ideology in healthcare that produces such effects.

Another critical view of the purpose of healthcare review websites is that they are mechanisms of control and governance. The idea that review websites potentially place 'healthcare professionals … under constant observation' (Wessely and Gerada, 2016, n.p.) can be linked to the panopticon as a symbol of social control, where people's perception of being under constant surveillance causes them to modify their behaviour to fit a social standard (Foucault, 1975). This is a theory that has been associated in particular with the idea of a 'rating culture', where newspaper opinion pieces (*The Guardian*, 2015, 2016) and dystopian TV shows (Brooker, 2016) have speculated on the way in which present-day practices like scoring Uber drivers and online consumer ratings will increasingly become a pervasive part of everyday life. An example of how review practices can be adopted for social control purposes is provided by the social credit system planned for China (Chorzempa, Triolo and Sacks, 2018), though further empirical research is needed to establish the extent to which the panoptic effect occurs with online healthcare reviews.

2.3.2 Written responses to online patient feedback

The literature reviewed in this subsection represents research that is most directly relevant to the object of focus in this thesis: staff replies to online patient feedback. This is an under-

researched topic where, until recently, the most closely related research findings came from studies on staff replies to online hotel reviews (Park and Allen, 2013; Zhang and Vásquez, 2014; Sparks, So and Bradley, 2016). However, there has recently been a budding interest in replies to online reviews of health services (Baines et al., 2018; Ramsey et al., 2019; Locock et al., 2020).

Given the scarcity of literature on this topic, the present subsection focuses primarily on these cited health studies, identified as the entirety of previous research on replies to online patient feedback. The aim of the review that follows is to provide an account of how healthcare staff respond to online patient feedback based on the literature, and to consider what the studies reveal about why staff respond in the way they do. The subsection also discusses what the studies suggest are the reasons for interest in the topic, before ending with an evaluation of how language is addressed by this previous research.

All three studies are from the field of health research and use content analysis, where themes are construed via a reading of the staff reply texts. Baines et al. (2018) investigates how content features contribute to the quality of replies to patient feedback. Thematic elements, judged to be markers of a quality response, were identified by the researchers in collaboration with patient-participants, who examined 183 replies to comments about adult mental health services from the review website Care Opinion. The number of markers (from 19 in total) was then identified for each text in the sample to provide an overall account of the quality of the staff replies.

In Baines et al. (2018), quality was found wanting in respect to the low occurrence of several markers of quality, content features that included staff responders providing a photo (in 2.7% of the sample replies) and an explanation of the responder's role (which occurred in no replies, even though 41 different staff roles were identified in the data). The more frequent quality features identified in the replies sample included politeness routines, thanks (in 71% of replies) and sign-offs judged to be polite (in 59% of replies), and signposted additional services (in 92.2% of replies) (pp. 893–4). The same quality framework created in Baines et al. (2018) was also used in Locock et al. (2020) which examined 96 replies to feedback about a hospital service on the same Care Opinion website. Though the specific results in that study were different, the same quality markers occurred with similar high or low frequency, with

the exception of signposted additional services, found to occur infrequently (in 13% of replies) (Locock et al., 2020, p. 6).

Quantifying staff replies in terms of the presence of content features that mark quality is not an aim shared by Ramsey et al. (2019), which instead analyses how healthcare workers respond to online patient feedback for the purpose of creating a typology of staff replies. To this end, 475 staff replies to feedback about hospital care, also posted on Care Opinion, were examined and themes identified on the basis that they could be used to distinguish between staff reply text type categories.

The text types identified were: *appreciative responses*, which the study represents as including features such as well-wishing, claims about boosted staff morale and reference to sharing feedback with staff; *generic responses*, described as ingenuine 'copied and pasted' replies lacking personalised details; *offline responses*, characterised as such on the evidence of staff encouraging offline communication with patients; and *transparent, conversational responses*, described as replies that embrace 'the open and transparent nature of online communication', which include expressions of compassion and details about how the feedback would be used. In this study, 58.5% of staff replies were classed as *appreciative responses*, 23.6% as *offline responses* and 10.5% as *generic responses*. The category representing the fewest staff replies was *transparent, conversational responses* which comprised 6.5% of texts in the sample (Ramsey et al., 2019, pp. 44–5).

Where the purpose is to provide an account of how healthcare staff reply to online feedback, the two analytic methods represented in these three studies are problematic. This is because they entail a partial representation of the content of replies. In Baines et al. (2018), only features judged salient by the researchers and patient-participants for assessing quality factor in the representation of staff replies provided by this study. In Ramsey et al. (2019), while all the content of replies may be considered during the analysis, the final identified categories of reply types represent staff replies in terms of dominant features only. This means other content features may be overlooked. The typological categories may also be problematic for not being discrete, as it is likely that overlap will occur. For example, *generic responses* could include appreciative elements, and offline contact could be encouraged in any of the other replies not classed as *offline responses*.

An approach that represents all parts of texts in the analysis is demonstrated in a study outside the field of health research: Zhang and Vásquez (2014). This study carried out a move analysis of 80 staff replies to online hotel reviews, a method developed in research on genre analysis (e.g. Swales, 1990; Biber et al., 2007). Moves are meaningful stages, referred to as 'discoursal or rhetorical units' in Swales (2004, p. 228) and 'logical manoeuvre[s]' in Mirador (2000, p. 47), that perform the communicative function of texts. Analysing moves involves 'assigning a pragmatic function' to different stages of a text and identifying the schematic structure that these constitute (Vergaro, 2004, p. 182).

In Zhang and Vásquez (2014), 10 moves for responding to online hotel reviews were identified. These are as follows, with the percentage of the hotel replies including each move in brackets: *express gratitude* (91%); *apologize for sources of trouble* (85%); *invitation for a second visit* (83%); *opening pleasantries* (80%); *proof of action* (79%); *acknowledge complaints/feedback* (66%); *refer to customer reviews* (63%); *closing pleasantries* (61%); *avoidance of reoccurring problems* (33%); and *solicit response* (30%) (p. 58).

Move analysis, as used in Zhang and Vásquez (2014), entails systematically encoding each sentence or clause in a text to identify what moves it contains. This contrasts with the ad hoc impressionistic method to identify content features used in Baines et al. (2018). By not using a systematic approach that considers all parts of texts, this study on the quality of staff replies to patient feedback is likely to have missed a potentially important quality marker: whether replies provide an explanation for the issue that may have caused negative feedback. This is a communicative function identified in Zhang and Vásquez (2014), represented by Move 7 – *refer to customer reviews*, where a distinction is made between references to reviews that recap details and references that entail more involved explanations.

Such explanation is likely to have a bearing on the perceived quality of replies, but in Baines et al. (2018) the only explanatory features identified as affecting quality are explanations of the role and reasons for a particular staff member responding, and explanations for certain services being signposted. While tailoring responses is identified as a feature that marks quality, this is represented as a stylistic issue – that is, avoiding impersonal standardised text – and does not distinguish between different levels of tailoring and the different ways these are likely to influence quality perceptions.

Research on staff replies to online patient feedback is not limited to identifying content. It also considers factors influencing the way that staff reply; specifically, the attitudes of staff to online feedback. For example, the replies identified as *transparent, conversational* in Ramsey et al. (2019), referred to above, are characterised as such because of the way they reflect the attitude of staff embracing online patient feedback. This attitude was determined by inferences made by the researchers based on the content of replies, as illustrated by the criteria they used for this category of reply:

> Responses appeared compassionate, recognised the value of patient feedback and delineated a clear plan around how the feedback would have a genuine impact on how care would be delivered subsequently. (p. 45)

Of the three studies on replies to patient feedback reviewed in this subsection, Locock et al. (2020) provides the fullest account of staff attitudes to feedback. In addition to the analysis of replies already noted, this study also presents findings from an analysis of interviews with 10 staff members who regularly respond to feedback on the website Care Opinion. The findings reveal a variety of staff attitudes, particularly in relation to anonymity. These include empathy with patients' desire for anonymity when they provide feedback, where staff recognise patients' fear of repercussions should their identity be known. They also include a view of anonymous feedback as an obstacle to staff being able to help patients. The view that anonymity casts doubt on the credibility of feedback because of the inability to verify claims and the feeling that patients may elaborate stories was also revealed in these interviews, corroborating the same identified in previous research on attitudes to patient feedback (Asprey et al., 2013).

As it is a relatively new topic of research, one motive for studying staff replies to online patient feedback is to contribute to knowledge about how healthcare workers respond to such feedback. This would account in particular for the main aim of Ramsey et al. (2019): to create a typology of staff replies. However, as may have already been suggested in this review, research on this topic is also motivated by wider implications of responding to feedback; that is, beyond describing how staff communicate with patients. This includes a specific interest in staff replies as a means by which patient satisfaction might be managed (Baines et al., 2018), and as an example of the changing nature of healthcare communication and relationships, specifically with respect to the theme of anonymity (Locock et al., 2020).

Managing patient satisfaction by providing quality replies is explained in Baines et al. (2018) through justice theory, a conceptual framework originating in research on business and hospitality. This theory was used in Doig (2004) which investigated staff responses to formal complaints about health services, and highlighted how responses to complaints have an important mitigation role to play when patients have had negative healthcare experiences.

Baines et al. (2018) applies justice theory to online patient feedback by linking the three dimensions of the theory to different aspects of staff replies that represent quality markers. These dimensions include *procedural justice*, the perception that procedures are fair, as – Baines et al. (2018) argues – encouraged by replies being timely and tailored (i.e. not standardised); *interactional justice*, the treatment of patients in an appropriate manner, as is said to be created by replies containing clear explanations and being polite; and *distributive justice*, the perception that the feedback will lead to fair outcomes – an effect, this study suggests, that can be created by staff providing improvement assurances and reporting the sharing of feedback with other staff (Baines et al., 2018, pp. 895–6).

Interest in the topic of staff replies to patient feedback for what they exemplify about changing healthcare communication and relationships is represented by Locock et al. (2020). This study explores how healthcare staff feel about online patient feedback and how they respond to it as parts of the same common concern. From the interview testimony of staff members who regularly write replies, Locock et al. (2020) highlights the communicative and relational challenges created by anonymous feedback posted in a public online context. This communicative situation produces what Speed, Davison and Gunnell (2016) have identified as the anonymity paradox, where patients may feel vulnerable providing feedback when they are not anonymous, and staff may feel vulnerable when patients are anonymous. It is for this reason that Locock et al. (2020) notes the need for staff 'support in dealing with anonymous feedback, and the uncomfortable situation of unequal power it may create' (p. 1).

As the present thesis is a linguistics study, previous research on staff replies to patient feedback merits evaluation with respect to its treatment of language. Therefore, the remainder of this review of staff replies literature will focus on the specific treatment of language in the three main studies that have been addressed in this subsection.

In Baines et al. (2018), language is explicitly referenced in relation to several of the quality-marking content features identified. This includes in relation to the use of thanks, where the wording *thanks* is represented as likely to produce a sarcastic effect while *thank you* is suggested as a preferred alternative (p. 891). Such a characterisation is predicated on the notion that words have constant meanings and functions. In fact, use of *thanks* will arguably only produce a sarcastic effect when there is a mismatch between the lexical meaning of gratitude and the intended opposite meaning of not being grateful, as can only be construed from the particular context of use (Taylor, 2015).

The treatment of language in Baines et al. (2018) is also problematic with respect to the content feature of sign-offs, which the study represents as marking quality when they take polite forms such as *best wishes* and *kind regards* (p. 894). However, the study is unclear about which sign-offs would constitute impolite forms. This prescriptive nature of specifying wording also arguably contradicts, elsewhere in the study, the representation of a standardised style as poor quality. These observations about language in Baines et al. (2018) also apply to Locock et al. (2020), which adopts the same framework.

In Ramsey et al. (2019), a consideration of language use is notably absent from explanations for the reply types identified. For example, *transparent, conversational responses* are represented as compassionate and valuing feedback, but there is no information about the criteria used to classify replies as such. How language is used is central to how a text is interpreted. A response may include a statement of values or the fact that staff feel sympathetic, but if this is formulaic and produces an insincere effect, then it would not be appropriate to classify it as being compassionate and valuing feedback. By not factoring in the role of language in determining text types, the typology presented in Ramsey et al. (2019) is arguably unsound.

In this thesis, I present research that addresses the shortcomings of the previous studies on staff replies to online patient feedback, in particular their false assumption, in using thematic and content analysis approaches, that the meaning and function of texts can be intuitively known through the act of reading. I do this by drawing on sound theories of discourse and using rigorous corpus-assisted methods to carry out a systematic analysis of the language of staff replies.

2.4 Relational work and politeness

2.4.1 The relational aspects of discourse in healthcare contexts

In Chapter 1, I discussed a key theme of this thesis, personalisation, specifically in relation to discourse and patient-centred care (see Sections 1.5.1 and 1.5.2), and in Section 2.2 I considered studies on the interpersonal function of language as part of an overview of health communication research. This section builds on the relational focus of these previous sections by first providing a brief summary of theory about the relational aspects of language, and then addressing linguistic relational practice, particularly the use of interpersonal strategies, in the context of healthcare.

The capacity of all language 'to express social and personal relations', what Halliday (1973) terms the 'interpersonal' function of language (p. 316), has been a primary focus of linguistics research on social relationships, particularly with respect to how these are managed through interaction. In order to explain how language links to social interactional practices, researchers have often used the theoretical concept of 'facework', which refers to how people manage their own and each other's self-image when interacting with one another (Goffman, 1967). This concept has been widely adopted in research on linguistic politeness, where politeness has been explained as the use of language to mitigate against face-threatening acts (FTAs) (Brown and Levinson, 1987). FTAs have been characterised as the violation of two main kinds of face needs: positive face, which refers to people's desire to be admired and liked, and negative face, which refers to people's desire to avoid impositions (Brown and Levinson, 1987).

Research on the relational aspects of language use has been dominated by a focus on politeness, particularly in the linguistics subdiscipline of pragmatics. Proponents of an alternative approach, represented by the discourse concept of 'relational work', argue that, by focusing on politeness, researchers tend to overlook other types of relational behaviour, such as politic/impolitic, appropriate/inappropriate and deliberately impolite behaviour (Locher and Watts, 2005). They also observe that the universal modelling of linguistic interpersonal behaviour associated with pragmatics entails a reduction of 'complex social realities' (Locher, 2014, p. 319), which are more fully addressed by the concept of relational work, as defined by Locher and Watts (2008):

Relational work refers to all aspects of the work invested by individuals in the construction, maintenance, reproduction and transformation of interpersonal relationships among those engaged in social practice. (p. 96)

This discourse approach, which includes politeness as a component of the more diffuse notion of 'relational work', is the one that I use in my thesis. My motivation for using this approach is that it is inclusive of the different ways that politeness and other interpersonal functions of language use may occur. It also allows for a wider consideration of the influence of different aspects of context on how NHS staff use language and the relational implications of this.

With a discourse approach to relational work, particular attention is given to the influence of the social, cultural and cognitive aspects of specific contexts on how people use and interpret the way language is used in interactions. From this perspective, interactions are seen as being mediated by 'knowledge of frames and norms of different practices' (Locher, 2014, p. 316). Frames are the 'sets of expectations' that people have about how to communicate and interpret communication in a given social activity (Jones, 2012, p. 21).

That frames may differ between interactional participants, and that they can be negotiated and change over the course of an encounter, highlights the importance of a discourse approach which pays close attention to the influence of context. This is illustrated by a study that investigates how language is used to manage trust in a doctor–patient interaction (O'Grady et al., 2013), where several frames are identified during the encounter, including a 'frame of … wariness and mistrust of the surgical profession' (p. 71), a 'frame of light-hearted relational talk' (p. 73) and a 'frame of oppositional talk' (p. 72).

While relational work is potentially unique to particular instances of interaction, patterns of practice across similar contexts can occur, especially in institutional contexts that entail task-oriented aims and established routines. In health-institutional contexts involving patient–professional interactions, patterns of practice take the form of relational strategies that are employed to achieve a number of aims, particularly rapport-building and empathy-signalling (Major and Holmes, 2008; de Silva et al., 2015). These serve the general purpose of encouraging patients to trust and open up to health professionals, which – as earlier identified

in Section 2.2 – can support clinical purposes such as treatment compliance and personal disclosure to aid diagnosis. They may also help patients to feel cared for, and therefore enact the principle of patient-centred care (see Section 1.5.1 for discussion of this concept).

Interpersonal communication approaches employed by health professionals in their interactions with patients include the use of both linguistic and non-linguistic strategies. Non-linguistic strategies have been observed in a study of sexual health consultations; these include doctors sitting closely and face-to-face with patients, regularly making eye contact and nodding or touching their arm or shoulder when discussing sensitive matters (de Silva et al., 2015). Another study highlights the use of context-specific actions as persuasive techniques to encourage patient trust, such as doctors making a display of setting aside referral letters in order to signal to patients that they want them to describe their problem in their own words (O'Grady et al., 2013).

The use of language for interpersonal purposes in healthcare contexts involves a variety of strategies. A number of these have been highlighted in three studies on the relational aspects of language in interactions between patients and health professionals: Major and Holmes (2008), de Silva et al. (2015) and O'Grady et al. (2013). Linguistic strategies identified in these studies (some occurring across several studies) include health professionals' use of:

- minimisers, such as *little* as in *little dressing* (Major and Holmes, 2008, p. 68), as might be used to put patients at ease during unpleasant clinical procedures
- hedging, such as by using modals (*may*, *might*, *could*, etc.) to allow the possibility of other viewpoints
- inclusive *we* to express solidarity with the patient and to implicate them as a collaborator in decisions about their own diagnosis and treatment
- features of an informal/conversational register, including first names, informal greetings, slang, colloquialisms, pragmatic markers and the use of humour
- non-clinical chat – that is, small talk – to establish shared knowledge and perspectives, and to 'minimise … hierarchical roles' (de Silva et al., 2015, p. 288)
- 'feedback markers such as *mm, okay, yes/yeah, all right*' (de Silva et al., 2015, p. 287) and expressions that indicate a positive concordant attitude to convey ongoing engagement and encouragement

- language that restates, paraphrases or completes what a patient has said, which serves to indicate listener involvement, establish interactional closeness and communicate empathy.

The final item in this list represents acts of linguistic mirroring that can be explained by accommodation theory. From a discourse perspective, this refers to the adoption of a communicative style that heightens similarity and reduces dissimilarity between interactants, and other modifications to language to make it accommodative of an addressee, such as by making it less technical (Coupland, 2010).

The relational strategies identified above all relate to synchronous healthcare interactions. Some of these are contingent on encounters being face-to-face, such as the non-linguistic strategies, or involving ongoing turns, as would be required for the use of feedback markers. Other strategies, including those relating to particular word choices or registers and linguistic mirroring, can be reproduced in asynchronous interactions, such as the kind examined in this thesis. The use of interpersonal strategies in asynchronous healthcare interactions is identified in a study of language used on a health advice website (Pounds, 2018). This study highlights an extensive use of empathetic expressions, which includes the following example of a clinician expressing empathy for how a patient might feel about a recommended treatment: 'Don't be discouraged if the medication does not work immediately' (p. 122).

So far, this section has addressed how language can be used interpersonally to manage relationships in interaction. The relational dimension of language also concerns what the use of language suggests about relationships beyond specific instances of interaction. For example, the use of particular registers (as defined in Section 1.3) can imply certain kinds of relationship, such as impersonal relationships where very formal registers are used. In healthcare, a service that is concerned with helping people in need, it might be assumed that a caring register would be the norm. However, a study investigating the presence of 'compassionate mentality words' in transcripts of interviews about compassion with mental health practitioners suggests this may not be the case (Crawford et al., 2013, p. 722). This study found a scarcity of words indicating compassion, with the authors concluding that:

the dominant registers of biomedicine, clinical technique/technology, and economic or productive efficiency might drive out compassionate words and phrases and ineluctably advance compassion depletion in health services. (p. 725)

The 'economic or productive efficiency' register identified here could be explained by public service marketisation (see Section 1.5.3), where the increasing priority of corporate-style values may result in a reduced sense in which healthcare relationships are based on care and compassion.

2.4.2 Politeness in service and healthcare contexts

In this section, I present a review of research on politeness relating to two contexts particularly relevant to the staff replies data: service and healthcare encounters. This builds on the discussion of politeness, and the related concept of facework, in the previous section.

People's experience of health issues can represent a very personal and sensitive concern for which politeness plays an important role. There are a variety of interactional situations in healthcare that entail a heightened risk of face-threatening acts (FTAs) when healthcare staff communicate with patients (Locher and Schnurr, 2017); for example, when staff are discussing intimate matters with patients (Brown and Crawford, 2009); when nurses are giving advice to new mothers, which can risk insinuating that they are failing to care for their babies properly (Heritage and Sefi, 1992); and when health professionals are breaking bad news to patients (Grainger et al., 2005).

Politeness is also relevant to the role of healthcare workers as advice-givers. Giving advice is potentially an FTA, for example, because advice may oppose what a patient feels or believes, or because the need for advice implies a patient's lack of knowledge (Locher, 2010). To address this, politeness strategies can be employed to help manage trust and expertise (Locher and Schnurr, 2017). Such strategies have been observed in a study of a health advice website (Locher, 2010), and include the advisor establishing their credentials as an expert, such as by referencing medical studies; mitigating against FTAs by using hedges when giving advice (e.g. 'It sounds as though'); and using face-enhancing strategies in the form of praise (e.g. 'You were perceptive') (p. 50).

Politeness and health communication in an online context has also been the focus of research on peer-to-peer interaction. This includes two studies, one on interaction in an online workshop about arthritis self-management (Harrison and Barlow, 2009), the other looking at interaction on a diabetes forum (Harvey and Koteyko, 2012), which both identify advice-givers' use of personal experience narratives to express empathy and mitigate against FTAs. The act of taking on the role of expert, associated with advice-giving, can also reduce the risk of face threats by serving as a warrant to give advice (Steehouder, 2005).

In previous research, politeness in healthcare interactions has sometimes been treated as a culturally specific phenomenon. For example, a study on interactions in a Kenyan hospital found that nurses would often engage in face-threatening behaviour when interacting with patients (Ojwang et al., 2010). This would involve acting impolitely, such as through criticism and reprimands, in response to which patients were found to be primarily concerned with preserving their own face and even that of the nurses. This arguably reflects a power imbalance in the relationship between healthcare staff and patients in Kenya, which is inverse to that observed in the UK context with respect to the influence of marketisation in the NHS (see Section 1.5.3), especially when this entails the treatment of patients as empowered consumers. Given that healthcare in the UK represents a service, particularly one associated with market norms despite its publicly funded status, the remainder of this section will consider politeness in the context of service encounters.

Research on the use of politeness during service encounters has highlighted the transactional nature of such an activity, where the need to balance sociability and efficiency means that politeness tends to occur as part of highly ritualised exchanges (Marquez Reiter and Bou-Franch, 2017). For example, a hotel receptionist, as part of the process of checking in a newly arrived guest, might be expected to greet them with a smile, make friendly small talk such as enquiring whether they have travelled far, and then, at the end of the exchange, wish them a happy stay. Service encounters typically involve limited time and familiarity, and therefore can be characterised by the tendency to involve the use of direct and positive politeness strategies (Gremler and Gwinner, 2000; Vergaro, 2004). This can entail the performance of exaggerated politeness, as exemplified by the expression 'have a nice day', famously associated with ending service transactions in the US. Such exaggerated politeness may be likely to produce an impolite effect, as Cameron (1997) observes:

prescribed linguistic formulas are intended to embody the organisation's commitment to service and politeness … Yet it seems many actual customers feel less than comfortable being addressed in customer care-speak. (p. 97)

This assessment of customer service politeness suggests a distinction between politeness as an effect of style and politeness as an interpersonal function of language use, where a company's branding in terms of caring takes precedence over whether customers feel cared for. However, the two can amount to the same thing if the commercial performance effort of staff is interpreted positively as a face concern (Pinto, 2011).

Politeness as a particular way of using language prescribed by companies to their employees can be very problematic. This is illustrated by the notion of emotional labour, which refers to workers' efforts to suppress their individual feelings in order to outwardly express an emotional state that is in keeping with the image a company wants to project (Hochschild, 1983; Ashforth and Humphrey, 1993; Wessel and Steiner, 2015). This raises questions about how much organisations should be permitted to infringe on the internal life-worlds of individuals, and about the potential negative implications of this for people's mental health. Such questions are especially pertinent in the context of the NHS, should marketisation lead to this kind of behaviour becoming increasingly expected and encouraged among healthcare staff.

2.5 The use of corpus linguistics to study discourse

This section presents a discussion of the main approach used in my thesis, one that combines corpus linguistics and discourse analysis. The section begins with a brief account of corpus linguistics, followed by an explanation of the concept of discourse. I will then discuss the rationale for using corpus linguistic methods to analyse discourse, and provide an overview of the main procedures used in a combined corpus linguistic and discourse analysis approach.

2.5.1 Corpus linguistics

Corpus linguistics describes the analysis of large 'bodies of electronically encoded text' using purpose-built software to identify linguistic patterns, typically based on frequency (Baker, 2006, p. 1). A primary principle in corpus linguistics is that only naturally occurring language

data should be used (McEnery and Wilson, 2001). In research on healthcare, this principle has been deemed particularly important for its potential implications for practice, as observed in a study that looks at how people talk online about eating disorders:

> corpus linguistics' emphasis on the analysis of authentic discourse is well suited to pedagogical interventions for healthcare providers. (Hunt and Harvey, 2015, p. 151)

The use of a corpus linguistic approach allows researchers to produce generalisable findings. In order to do this, a corpus representing a particular language or text type needs to be balanced and representative, which is to say it should include all variations of how a language or text type is used by different types of speaker in different situations, and in similar proportions to how this occurs in the general-world context from which the data originates (McEnery and Hardie, 2012). While there is a lack of empirical evidence for how to achieve a fully balanced and representative corpus, these concepts to guide the building of a corpus are nevertheless important (McEnery and Hardie, 2012). Sometimes, the sampling principles of balance and representativeness are not required. This occurs when a corpus represents the entirety of a text type under examination, such as all the articles from a single newspaper for a specified period (Baker, 2010), or all the staff replies to feedback on a healthcare review website for a given period, as is the case with the present study.

Linguistic patterns identified using corpus analysis software are often based on individual words, though the unit of analysis can also include clusters (repeated multi-word units), or parts of speech (e.g. nouns, adverbs) when a corpus has been annotated with such information (Baker, 2006). A corpus can also include metadata about the situation in which texts have been produced or the identity of text producers (e.g. age, sex, socio-economic background), which allows analysts to identify links between linguistic patterns and different social contexts and groups (Baker, 2006). Metadata was tagged by the NHS provider of the corpus examined in this thesis. It includes details about where and when each text in the corpus was produced, the type of service provider that produced it and the patient feedback linked to each reply (see Chapter 3 for more details). A further type of annotation is the semantic categories of words where, with a reasonable degree of accuracy, software can be used to assign words to categories and analyse patterns of meaning in a corpus (Rayson, 2008).

Corpus linguistic studies are generally distinguished based on two main approaches: 'corpus-based' and 'corpus-driven' (Tognini-Bonelli, 2001). 'Corpus-based' research uses corpus data to investigate existing theories, whereas 'corpus-driven' refers to research where theories about language originate from the corpus itself (McEnery and Hardie, 2012); in practice, though, corpus linguistic studies can potentially involve elements of both. The distinction between corpus-based and corpus-driven approaches is arguably the difference between corpus linguistics as a method and corpus linguistics as a theory (McEnery and Hardie, 2012). However, there has been 'some disagreement about whether corpus linguistics is a methodology or a theory of language (or both)' (Baker, 2010, p. 6). While it may be contentious to categorically define it completely as one or the other, corpus linguistics undoubtedly has significant implications for theory, as suggested by Hunston's (2010) description of it as 'a field where technological advancement and theoretical development go hand in hand' (p. 4).

2.5.2 Discourse

This subsection contributes additional discussion of the term 'discourse' which was briefly defined at the start of this thesis (see Section 1.3). Discourse is a potentially ambiguous term that has been variously defined and consists of 'a wide set of overlapping meanings' (Baker and McEnery, 2015, p. 4). Two often-quoted definitions are that discourse refers to 'language in use' (Brown and Yule, 1983) and that it is 'language above the sentence or above the clause' (Stubbs, 1983, p. 1). The first is very broad in that it arguably describes all naturally occurring language, while the second is narrow, in the sense that it essentially represents a definition of a text.

A key component of discourse is context, and this has featured in other more precise definitions of the term, which generally represent discourse as a relationship between context and linguistic form. For example, Widdowson (2004) describes discourse as 'the pragmatic process of meaning negotiation' (p. 8), which highlights the interactionally situated nature of discourse. Other definitions do not confine themselves to language, and refer instead to 'semiotic resources', used to perform practices that 'shape their particular professional, institutional and social worlds' (Candlin, 1997, cited in Hocking, 2015, p. 192).

When the purpose of analysis is to describe discourses – that is, to provide an account of how certain language features may be associated with particular contexts of use – then discourse can be treated as synonymous with register. Register refers to 'text varieties of a language associated with particular situations of use' (Biber, 2013, p. 191).

Closely linked to the concept of register is genre. A genre is a 'recognisable communicative event' (Bhatia, 1993, p. 13) that consists of a familiar structure and 'communicative function' (Flowerdew, 2012, p. 138). Genres are events made up of stages (Flowerdew, 2012, p. 139), and they are generally characterised as the means used to 'get things done' (Jones, 2012, p. 44). When analysts are addressing the structure and function of communicative events, discourse as a set of semiotic resources to perform social practices can be conceptualised as genre. Similarly, when analysts are concerned with the storytelling aspects of language use, the term discourse can be used synonymously with narrative (Benwell and Stokoe, 2006, p. 42).

The definitions of discourse presented in this section are oriented to texts, although – as was identified in Chapter 1 – discourse can also be defined in more abstract terms as a way of seeing the world (see Section 1.3 for Foucault's definition). Fairclough (1992) draws from Foucault in his representation of discourse as social practice and shaped by power relations, though he criticises Foucault's tendency to represent people as being 'helplessly subjected to immovable systems of power' and 'the absence of text and textual analysis' in his work (p. 57). While a sense of discourse as constituting social practice is used in this thesis, it is only used to the extent that clear evidence of such can be found in the language, and the use of corpus methods provides the means by which to do this.

The approach to discourse used in this thesis is an inclusive one that is open to interpreting emergent findings based on how they may best reflect the definitions provided in this section.

2.5.3 Combining corpus linguistics and discourse analysis: rationale

A general argument for combining corpus and discourse approaches is that it involves using the strengths of each to address the weaknesses of the other (Hardt-Mautner, 1995). The use of corpus methods provides 'statistically reliable' data (McEnery and Wilson, 2001, p. 77), and when corpora are balanced and representative, it also helps 'guard against cherry-

picking', as might (unconsciously) occur when discourse analysts select their data sample (Baker and McEnery, 2015, p. 5). The use of qualitative discourse analytic methods provides 'greater richness and precision' (McEnery and Wilson, 2001, p. 77), and addresses the 'disregard for context' that has been the criticism of corpus approaches that are primarily quantitative (Marchi and Taylor, 2018, p. 4).

Marchi and Taylor (2018) highlights how mixing corpus linguistic and discourse analytic methods represents a reconciling where previously there has been paradigmatic opposition between quantitative corpus and qualitative discourse approaches. This allows for a more creative research question and data-led approach to the study of language (Marchi and Taylor, 2018). The versatility of corpus methods has been illustrated by research on triangulation, notably in a work edited by Baker and Egbert (2016) where 10 researchers used their own corpus approaches to analyse the same data using the same research questions. Marchi and Taylor (2018) note that 'all forms of triangulation hold creative power' (p. 6), as they allow researchers to explore data in different ways and address complexity. This arguably holds true for corpus methods in general, given their versatility, and the ongoing technological advances that allow analysts to approach data in different ways (see Tognini-Bonelli, 2010, for a brief history of technological developments in corpus linguistics). The mixing of corpus and discourse analytic methods has taken several forms, with perhaps the two most notable being corpus-assisted discourse studies (CADS) and corpus-based critical discourse analysis (CDA). CADS is specifically termed 'corpus-assisted' to imply that the particular corpus method used assists rather than constitutes the whole analysis (Partington et al., 2013). A main aim of CADS is to uncover 'non-obvious meaning', the rationale being that the use of traditional approaches to discourse analysis would suffice to identify obvious meaning (Partington et al., 2013, p. 11). Non-obvious meanings are also more likely to lead to unexpected findings, and the inductive nature of corpus methods means they can potentially lead to serendipitous discoveries that suggest new themes, phenomena and lines of enquiry (Partington et al., 2013).

CADS has a general sense that refers to any combination of corpus and discourse methods, although studies that use CADS have tended to be non-critical and focus on media and political discourse (Baker and McEnery, 2015). As for corpus-based CDA, mainly developed at Lancaster University (e.g. Hardt-Mautner, 1995; Baker et al., 2008), studies that have adopted this approach tend to take an overtly critical stance. This aspect of CDA research

leaves it particularly open to accusations of selectivity with respect to data samples and the analytic categories used, where the pre-existing critical stance of researchers may make them more susceptible to wanting to 'prove a point' (Baker et al., 2008, p. 283). The advantage of using corpus methods, where categories emerge bottom-up, is that they can help counter such accusations and reduce the influence of bias. However, corpus methods do not eliminate bias, as highlighted by scholars in the field who emphasise the need to reflect on how factors such as corpus design, different statistical measures and analytic choices may affect findings (Marchi and Taylor, 2018).

In my thesis, I do not take an overtly critical stance at the outset, as might have been done by adopting a CDA approach. There is no fundamental problem with the practice of healthcare staff responding to feedback that would warrant a systematic critical analysis of the data. That said, a general CADS approach does not preclude making critical observations about emergent findings when there is call to do so, and this is the approach I use in my study.

2.5.4 Combining corpus linguistics and discourse analysis: application

How corpus linguistic methods combine with discourse analysis methods is suggested by the approach to analysing a corpus in Baker and McEnery (2015, pp. 2–3), where four stages of analysis are identified. The first stage involves identifying and describing quantitative linguistic patterns, which is followed by a second stage of interpreting those patterns, and then a third stage of explaining those patterns, as might be achieved in a variety of ways such as through further closer analysis of the data and analysing context. An optional fourth stage is evaluation, should the analyst decide to take a critical position in relation to the findings.

This four-stage approach illustrates how corpus analysis is initially quantitative and becomes progressively more qualitative, and is therefore conducive to being used to analyse discourse. A more detailed representation of the stages involved when using corpus methods to analyse discourse is provided in Baker et al. (2008), which identifies nine stages, including several where new hypotheses or research questions might be formulated. This reflects how such an approach does not necessarily follow a linear progression but often can be circular.

The analysis of discourse using corpus methods typically involves following one, or any combination, of four main techniques, which can be summed up as follows: word frequency, keywords, collocates and concordances (Baker, 2006).

Word frequency refers to identifying the frequency of words in a corpus. Language has been characterised as a system based on the tension between the predictable adherence to rules and 'free choice' (Baker, 2006, p. 48). In this way, frequency can be an indicator of choice, such as when certain words occur higher on a frequency list compared to potential alternatives. Patterns of choice highlighted by word frequency can provide a focus for a closer analysis of a corpus. They can also help reveal discourses and attitudes. For example, when sets of words associated with one social group are more frequent than those associated with its binary opposite, such as words relating to gender or sexuality, this may reflect either the dominance of or tendency to problematise that group (Baker, 2010, p. 125).

Word frequency as a corpus procedure has been used in several studies of healthcare. These include for the purpose of analysing evaluation in patient feedback, where the most frequent positive and negative evaluative words can be used as an entry point for analysis (Baker, Brookes and Evans, 2019). They also include for the purpose of identifying health practitioners' topic focus when interviewed about compassion (Crawford et al., 2013), where the lower-than-expected frequency of words associated with compassion is used as evidence of a lack of a compassionate mentality in healthcare.

Though useful for targeted purposes, word frequency lists are often not effective indicators of salience as they tend to be dominated by words that an analyst would expect to find, such as grammatical words and those associated with the topic area of a given corpus (Baker, 2006). A more effective indication of salience is provided by keywords. A keyword is a word that is statistically more frequent in one corpus when compared with its occurrence in another (Baker, 2006). Keywords provide entry-points for analysing a corpus. They can also highlight the distinct characteristics of a discourse represented by a particular corpus. The nature of these characteristics depends on the comparative corpus used to identify keywords. If it belongs to a different genre than the corpus under examination, then keywords highlighted may reflect that genre difference; if it belongs to the same genre, then keywords might be more likely to represent topic differences (Baker, 2010).

The choice of comparative corpus when calculating keywords depends on research questions and the kind of data being analysed. Likewise, these can also inform the choice of statistical measure used to calculate keywords (for a discussion of different keywords measures see Gabrielatos, 2018). When calculating keywords for discourse analytic purposes, analysts can tend to focus on lexical keywords because of the way these are useful for revealing discursive strategies (Baker, 2010, p. 134). However, as McEnery (2006) found when looking at the keyword 'and', grammatical keywords can also be relevant for looking at discourse.

Keyword analysis has been used in studies on health-related matters; for example, a study where keywords were used to identify salient linguistic features so as to investigate how people talk about eating disorders in an online forum (Hunt and Harvey, 2015). Another example is the use of a comparative keyword analysis between corpora, one consisting of posts by men on a prostate cancer online forum, and the other posts by women on a breast cancer online forum, to highlight gender-based differences in how people talk about illness (Seale et al., 2006).

Another corpus-based technique that can be used to study discourse is collocation analysis. Collocates are words that co-occur at a rate greater than chance; that is, where the nature of the co-occurrence is statistically significant (Baker, 2006). As with the corpus techniques already identified, collocates are based on frequency and, like keywords, they involve the use of particular statistical measures (see Chapter 3 for the choice and rationale of measures used in this thesis). Collocates provide information about the meaning of words based on how they occur relative to other words; that is, meaning based on how language is used rather than dictionary definitions (Baker, 2006, p. 96). Collocates tend to be identified for words of interest, such as those representing concepts deemed culturally salient, though more commonly they are used to analyse corpus keywords, and in this way they can represent a second stage of corpus analysis.

Health studies that use collocates to develop the analysis of keywords include Harvey and Brown (2012). In this study, keywords were generated for a corpus of posts from an adolescent health website. These keywords were grouped into topic categories, which helped to highlight the recurrence of keywords relating to self-harm in the 'mental health' category. A collocation analysis of this group of keywords was then carried out to help reveal adolescents' attitudes to and understanding of self-harm. A similar study (Harvey, 2012) was

also carried out with depression keywords, where collocates were again used to explore further patterns in meaning and function for the purpose of gaining insight into how adolescents talk about a mental health issue.

Collocation is linked to the concept of semantic prosody, which refers to the aspect of the meaning of a word that is imbued with the meaning of its collocates (Louw, 1993). These meaning associations between words can embody assumptions that may represent implicit ideologies (Baker, 2010, p. 127). Researchers often distinguish between negative and positive prosodies. For example, a negative prosody was identified by Sinclair (1991) as being associated with the phrase 'set in' because of its tendency to co-occur with words like 'rot', which has strong negative associations. Words with negative prosodies have also been identified in research on patient feedback (Baker, Brookes and Evans, 2019). For example, the word 'attitude', which would often collocate with negative evaluation words (e.g. 'bad'), was sometimes found to represent negative feedback even when not occurring with such evaluation words, as when patients described staff as 'having' an attitude (p. 51). The implicit ideologies represented by semantic prosody can be difficult to unpack and criticise, though analysing collocates represents one way to do this (Baker, 2010; Hunston, 2002).

The final corpus procedure for analysing discourse is concordance analysis. Unlike the other procedures, concordances are not based on frequency but represent a tool for carrying out qualitative analysis (Baker, 2006). This takes the form of software representing multiple lines of a searched item surrounded by a snapshot of text to its left and right (see Hunston, 2002, for a detailed description of concordances). The limited context provided by concordance lines can sometimes necessitate these being expanded, and corpus software typically includes options to expand lines or display full texts; for example, the corpus processing system CQPweb (Hardie, 2012) which is used in this study. In addition to providing a means for carrying out a qualitative analysis of features across multiple texts, concordances can also provide important context for construing accurate information about how words are used, which cannot always be inferred from looking at keywords and collocates alone (Baker, 2010, p. 133).

Concordances are often used in studies in which keywords and collocates are being analysed, as is the case with many healthcare studies (e.g. Hunt and Harvey, 2015; Harvey, 2012). They can help reveal interesting findings, such as in a recent study on the language of patient

feedback (Baker, Brookes and Evans, 2019). Here, a review of concordances of the keyword 'you', in feedback about GP practices, revealed that in the majority of instances it was used in the generic sense to express the typicality of experience; this highlights the common tendency for GP practice patients to represent their experiences as generalisable (p. 111). In that study, 100 random concordances were used, this figure based on a 'saturation point sampling procedure' having been adopted to determine that no new patterns were identified beyond the 100th text randomly selected for a sample analysis (pp. 44–5). The same sample size is used in this thesis to analyse random concordances.

2.6 A review of previous research on text reuse

This section presents a review of research on text reuse: the practice whereby pre-existing text is used, either partially or fully, to create new texts. Text reuse has been an object of interest to researchers for a variety of reasons. An account of these is provided in the following review, along with a description of the different methods, themes and data that feature in previous research on the topic. A large proportion of the studies examined are from the field of computer science, and therefore, given the discourse focus of the present study, this review also includes some evaluation of these with respect to the study of language use. This section also considers how text reuse relates to theory on language and discourse, a connection that is mostly absent in the studies reviewed.

Research on text reuse is often concerned with detection, usually to identify unwanted duplicates for removal when compiling corpora or to reveal evidence of plagiarism. Text reuse that is surplus to requirements is especially an issue with web-based corpora which can contain extensive boilerplate – 'redundant and automatically inserted material like menus, copyright notices, navigational elements, etc' (Schafer, 2017, p. 873) – which has 'limited or no value for the purposes of studying language use' (Pecina et al., 2014, p. 150). Judging which kind of text reuse has value depends on the purpose of individual researchers. For example, when developing a corpus to help create an English-Irish dictionary, Kilgarriff et al. (2006) do not regard 'rewritten sentence[s]' (p. 136) as duplicates. This is because their aim is to provide evidence for lexicographers of the variety of 'collocational and grammatical patterns' (p. 127) that can occur in Irish and Hiberno-English. In this respect, any different way these languages are used is of interest to the researchers, so redundant duplicates represent texts that are substantially the same as other texts in the corpus.

To detect reused text for the purpose of cleaning their corpus, Kilgarriff et al. (2006) use an algorithm that identifies duplicates based on their sharing 60% or more identical sentences with other texts in the corpus. However, this method of detection of obvious surface similarity is not suitable for detecting instances where authors may have tried to disguise their text reuse. To detect more subtle text reuse below the sentence level, as can occur in cases of plagiarism, the method often favoured uses software to identify *n*-gram overlapping between texts. An *n*-gram is a sequence of words of a specified length, and when used for the purposes of text reuse detection, it can involve texts being represented as 'unordered collection[s] of … *n*-grams' and then compared for similarity above a given threshold (Smith et al., 2014, n.p.).

The use of *n*-gram overlapping as a method for detecting text reuse can vary from study to study, both in terms of the other complementary measures that may be used and the size of the *n*-gram identified. For example, in their study on plagiarism in a corpus of scientific articles, Citron and Ginsparg (2014) disregard parts of texts that are likely to flag duplication (e.g. references and block quotes) and use seven-word sequences (7-grams) shared between articles to detect text reuse. The choice of the 7-gram unit is based on the rationale that it removes 'sensitivity to commonly used shorter sequences' (p. 26).

The length of the *n*-grams searched can vary because of differences between languages. Belinkov et al. (2018) argue that 'frequently-recurring Hebrew and Aramaic formulaic phrases tend to be limited to two (sometimes three) words', which makes 4-grams an appropriate unit for text reuse detection. Genre can also have a bearing on which size *n*-gram is most suitable to use. For example, Smith et al. (2014) note that 5–7-grams are suitable for detecting text reuse in news articles, while longer *n*-grams are suitable for legislative texts where text reuse tends to be more continuous. The appropriateness of the length of the *n*-gram depends on the prevalence of text reuse in a corpus. In documents with high text reuse, shorter *n*-grams will generate a large number of results that will be time-consuming to process; in documents where text reuse may be disguised by rewording, such as when plagiarism occurs, longer *n*-grams will likely fail to detect many instances of text being reused. Therefore, for researchers using the *n*-gram overlapping method, the choice of *n*-gram size can involve a 'trade-off between accuracy and efficiency' (Smith et al., 2014, n.p.).

In research that uses *n*-gram overlapping to detect plagiarism, the extent to which the length and number of common *n*-grams between texts counts as plagiarism is debatable, and can

depend on genre norms. For example, where different newspapers report the same 'facts' about an event, and even reproduce copy provided by shared newswire services, this increases the likelihood of text reuse and makes identifying news plagiarism challenging (Sousa-Silva, 2015). In academic publishing, plagiarism thresholds are a source of controversy. Moskovitz (2017) reflects on the grey area between plagiarism and legitimate text recycling in health science journals, arguing that, while authors republishing previous findings counts as plagiarism, the verbatim reuse of text representing technical information should be treated as acceptable.

In studies on text reuse, there is sometimes a tendency for all text reuse to be conflated with the kind of spurious activity associated with plagiarism. Hagen et al. (2017) exemplify this tendency by describing 'suspicious documents' (n.p.) when referring to text reuse in general. The idea of text reuse representing a deception to be exposed using state-of-the-art algorithms helps explain the emphasis – in a large proportion of research on the topic – on establishing the fact and quantity of text reuse. However, this risks overlooking important questions about the nature of text reuse in a given situation; for example, does it represent plagiarism, and if not, what does it represent instead? A suggestion above was that text reuse could represent the norms of a particular genre. With studies that are solely concerned with text reuse detection, there is a risk of reductionism if they treat texts as quantifiable material items that exist independently of language use practices and norms.

In some research on text reuse, there is a focus on how language use links to context. This is the case with a number of studies on legislative texts. Unlike text reuse research where the emphasis is on detection, in the case of legislation, where text reuse may be prevalent between, for example, proposals and passed bills, obvious similarities can be detected without the use of software. Instead, the primary interest of researchers tends to be in the differences between texts that are highly similar; for example, the differences between legislative proposals and final legislation represent amendments made before legislation was passed. As shown in a study on the EU legislature (Cross and Hermansson, 2017), this can provide insights into the influence of different parties and processes on the passing of legislation. In this study, a minimum edit distance algorithm is used that measures the number of 'insertions, deletions or substitutions' in final legislation when compared to proposals (p. 589).

Where interest does lie in the similarity between legislative texts is in research that considers the flow of ideas and wording between different documents (e.g. Linder et al., 2018; Wilkerson, Smith and Stramp, 2015). Such research can help reveal the textual source of legislation and thereby provide important information about how certain laws may have come into being. For example, Burgess et al. (2016) investigates how much US state legislation is based on the reuse of legislation already passed in other states or on legislative proposals produced by interest groups. The authors note how the limited resources available to produce original legislation encourage this kind of text reuse, a practice that is problematic as it can involve legislation being passed without due consideration.

To identify text reuse in the case of legislation, researchers use a method different to the *n*-gram overlapping approach used for plagiarism detection. With this approach, comparing collections of unordered word sequences can suffice for detecting the fact of reuse above a given threshold. However, a closer alignment of text reuse is necessary to look at legislation when the object of the research is to identify how much the same ideas and policies have been reproduced. The local alignment algorithm typically used in this context identifies the longest common subsequences between the texts being compared (Wilkerson, Smith and Stramp, 2015; Burgess et al., 2016). The longest common subsequences are the continuous strings of words shared between the texts, with a certain number of 'mismatches and gaps' permitted to allow for subtle changes in wording (Linder et al., 2018, p. 6).

Local alignment methods, such as those used in research on legislative text reuse, contrast with more global methods for identifying text reuse where general patterns of similarity are detected. These include bag-of-words methods where the number of common words between documents is used to identify text reuse (Linder et al., 2018); the use of keyword comparison to detect close topic similarity between texts (Lulu, Belkhouche and Harous, 2016); and calculating 'statistical properties' such as the 'number of sentences' in a text and 'average number of tokens' in each sentence (Sharjeel, Nawab and Rayson, 2017, p. 795). Such global approaches can be used to identify candidate texts where text reuse is likely to have occurred so that these can then be processed using more local alignment measures. Several of the studies considered in this review use a combination of global and local approaches (e.g. Colavizza, Infelise and Kaplan, 2015).

In research on plagiarism, Olsson (2004) identifies both local and global methods for text reuse detection. These include local detection where word-for-word plagiarism is identified when 'identical strings of more than 40 characters occur in two or more texts alleged to have been produced independently of each other' (p. 114); and global detection of mosaic plagiarism, which is identified based on two texts of 250 words sharing more than 30% lexical similarity (of words, not sentences) (p. 116).

The need to sometimes combine global and local methods reflects the technical obstacles that can arise in research on text reuse. With big data, comparing all the elements of a text with all the elements of tens of thousands of other texts, as well as information about those elements (such as where they occur relative to each other), can entail lengthy and expensive processing. For this reason, a primary concern of computer science research on text reuse has been to develop tools and methods that reduce costs and increase efficiency. To this end, many studies have employed techniques such as the use of vectors (Sharjeel, Nawab and Rayson, 2017; Alshomary et al., 2018; Soto et al., 2015), and reduced the size of texts via hashing or by transforming them into more manageable representative signatures (Lulu, Belkhouche and Harous, 2016; Leskovec, Rajaraman and Ullman, 2014). In this respect, a large proportion of research on text reuse is computational and focuses on the development of efficient and suitable algorithms for text reuse detection.

With its focus on the technical aspects of detection methods, research on text reuse can often fail to fully engage with the sense in which text reuse is about language use. This can also be the case with humanities studies. For example, Smith et al. (2014) investigate how text reuse can provide evidence of social networks, and Colavizza, Infelise and Kaplan (2015) use patterns of text reuse to provide an account of an 'information exchange system' shared by 17th-century Italian newspapers. In these studies, patterns of text reuse are primarily used as a means to quantify tendencies relating to language, but they provide little information about language use itself.

The literature on text reuse considered in this section does include some evidence of researchers engaging with linguistic and discourse features of reused text. A notable example is Sharjeel, Nawab and Rayson (2017), who report on their manual annotation of a corpus, in the Urdu language, of 600 news agency articles (source documents) and 600 newspaper stories (derived documents). Although the purpose of this annotation is to create an

evaluation measure for testing the effectiveness of text reuse detection algorithms, it nevertheless presents a useful topology in which text reuse is conceptualised as different text types and language use choices. The three text types identified are 'wholly derived', 'partially derived' and 'non-derived' texts (p. 777). As for language use choices, these are represented by the following six classes of paraphrase mechanisms based on 'linguistic phenomena underlying paraphrasing' (p. 785):

1. 'Morphology-based changes' (e.g. when the inflectional form of a word has been altered)
2. 'Lexicon-based changes' (e.g. the use of synonyms or antonyms, different spelling and adding or removing words without changing the meaning)
3. 'Syntax-based changes' (e.g. 'negation switching')
4. 'Discourse-based changes' (e.g. changing between an indirect and direct style)
5. 'Semantic-based changes' (e.g. rephrasing that produces similar but different meaning)
6. 'Miscellaneous changes' (e.g. adding or removing text, changes in word order).

(pp. 786–91)

In its engagement with the linguistic aspects of text reuse, Sharjeel, Nawab and Rayson (2017) is more the exception than the rule in research on this topic. In many of the studies reviewed, text reuse tends to be treated as the material product of a physical processing activity, which fails to engage with the sense in which it is linked to formulaic language that results from a cognitive process. This link is represented in the following excerpt from Forsyth and Grabowski (2015):

> we observe a polarity in linguistic expression – from regurgitated boilerplate on one side to creative innovation on the other. The term 'formulaic language' denotes language nearer the left pole than the right, less rigid than simple cut-&-paste but nevertheless allowing only a restricted range of expressive options. (p. 1)

In their paper, which investigates ways of measuring the extent to which different registers are formulaic, Forsyth and Grabowski (2015) note that, despite the scope for creativity, language mostly tends to follow predictable routes. To some degree, this echoes Sinclair's idiom principle: the idea that language consists of a large number of 'preconstructed multi-

word combinations' (Erman and Warren, 2000, p. 29). In this regard, what may occur as a copy-and-paste process with text reuse is not entirely dissimilar to the reusing of ready-made constructions that can occur naturally.

Text reuse can also be viewed in terms of discourse concepts like interdiscursivity, which refers to the 'constitution of a text from diverse discourses and genres' (Fairclough, 1993, p. 138). The sense in which this represents reuse is conveyed in Dunn (2006), who defines 'type interdiscursivity' as 're-creating a genre', distinguishable from 'token interdiscursivity' which is defined as 're-creating a particular text' (p. 153). In Dunn (2006), a study on the discourse of Japanese wedding speeches, the latter, more generally referred to as intertextuality, refers to quoted passages. As for type interdiscursivity, this refers to the use of conventionalised formulaic constructions identifiable with a particular genre, in this case wedding speeches. As this example illustrates, discourse at the level of genre can be viewed as the practice of language reuse, whether in the form of material text reuse or reuse in the sense of genre-specific mental scripts.

Overall, research identifiable with the term 'text reuse', which includes the majority of the papers considered in this review, tends either to be about practical applications, such as plagiarism detection and corpus cleaning, or quantifying textual and social tendencies. However, in studies that explore automated ways of processing corpora that contain high amounts of text reuse, there is limited engagement with the linguistic and discourse aspects of text reuse. As the brief consideration of how language and discourse are inherently linked to text reuse suggests, text reuse is not material matter that can be processed separately to addressing potentially difficult questions about language; for example, where does text reuse end and formulaic language begin? Even in the study on text reuse that has most engaged with language of those reviewed here (Sharjeel, Nawab and Rayson, 2017), data is used where source and derived texts are known beforehand.

However, how text is reused in practice is messier and more complicated than is represented by the neat example of the data used in this paper. As the authors themselves note: 'Freely available and easily accessible large online repositories are not only making reuse of text more common in society but also harder to detect' (Sharjeel, Nawab and Rayson, 2017, p. 777). To address this challenge, it is necessary not only to develop more sophisticated software, but also to engage more with the language and discourse of text reuse, as will be done in the present study. In summary, my study is distinguishable from previous corpus

research on text reuse in terms of the type of corpus examined, my research questions, the reasons for text reuse and my focus on language. These will be discussed further in Chapter 3 on the study's method.

2.7 Conclusion

As anticipated in Chapter 1, this chapter has contextualised the present study in relation to previous research and discussed a variety of relevant themes and theories. This particularly includes the relational aspects of language and healthcare, which were discussed in relation to several topic areas in the overview of health communication at the start of the chapter (Section 2.2), such as the importance of balancing the medical and personal interests of patients in healthcare interactions, and the growing interest in research on patient experience. A closer consideration of how this topic has been addressed by linguistics research was later provided in Section 2.4 on relational work and politeness.

Section 2.3.2 reviewed several recent studies that are key because they specifically address written replies to online patient feedback. Further, Section 2.6 on text reuse provided an overview of the topic, and highlighted some gaps in research that will be discussed further in the thesis' Conclusion (Chapter 8).

The literature review has also discussed concepts and issues relating to the main approach used in this study, corpus-assisted discourse analysis (CADS). The specific methods that I propose to use in my thesis will be described in Chapter 3 that follows.

Chapter 3: Method

3.1 Introduction

The overall method used in this study is corpus-assisted discourse analysis (Partington et al., 2013; Baker and McEnery, 2015; Marchi and Taylor, 2018 – see Section 2.5 for a discussion of how corpus linguistic methods assist the analysis of discourse). In this chapter, I will present details of the particular way I have used a combined corpus and discourse approach to analyse NHS responses to online patient feedback. This chapter also provides an account of the data used in this study and specifies the methods used on different parts of the data.

The purpose of the method used in this thesis is to address both the general aim of the thesis and its specific research questions. To this end, the corpus linguistic element of the approach is particularly useful for providing a representative account of how NHS staff use language when responding to feedback. This is because it produces results that are based on patterns identified across tens of thousands of texts produced by staff across the NHS within a given time period. In this way, when the analysis addresses specific research questions, such as RQ2 and RQ3, then findings about how linguistic choices position staff and reflect certain discourses are generalisable as a feature of NHS responses to feedback.

The structure of the chapter is as follows: a summary of the software used in this study is provided in the next section (3.2). This is followed by an overview of the data in Section 3.3. Next, an account of the particular way the data has been prepared for use in this study is presented in Section 3.4. This section addresses the issue of the large amount of text reuse found in the staff replies corpus, and in this regard also goes some way towards addressing RQ4 of the thesis (*How can corpus-assisted discourse analysis be used on data consisting of a large amount of reused text?*).

Section 3.5 outlines the overall corpus-assisted discourse analysis approach used in this study in terms of the analytical stages involved; it also identifies the variety of discourse analytical categories that have been applied in the analysis. This method relates to the two main thesis research questions, RQ2 and RQ3, which are concerned with how linguistic choices position staff and patients and how they reflect discourses, respectively. The same is the case with the specific methods detailed in the four sections that follow, where particular methods may be

more or less applicable to different parts of the data (as indicated in those sections), but all are intended to produce findings that address RQ2 and RQ3.

These four sections are: Sections 3.6 and 3.7, on keywords and repeated word sequences, respectively, which present details of corpus-assisted methods that are used as starting points for analysis of the data; Section 3.8, on concordances and collocates, which represents a secondary analysis stage; and Section 3.9, on text sampling methods, which relates to the qualitative analysis of samples carried out in this study. The section that follows these, Section 3.10, provides details of how staff replies are analysed in terms of linked data, which addresses RQ1 of the thesis (*What factors, such as type of feedback (whether positive or negative) and provider type, influence different uses of language?*). The chapter concludes with Section 3.11 which summarises and reflects on the different methods outlined in the chapter.

3.2 Analysis software

In this section, I provide a description of the main software tools I have used in my study, which are WordSmith 7, CQPweb and Microsoft Excel. WordSmith 7 (Scott, 2016) is a downloadable concordancing program that can be used to process a corpus and identify patterns that support an analysis of language data using corpus linguistic methods. These patterns include word lists, keywords, collocates and clusters. In addition to its main features, WordSmith 7 includes further functions for processing a corpus, two of which are used in the analysis reported in this thesis.

These are Duplicate Contents and Boilerplate Text, developed for version 7 of WordSmith by Mike Scott (the creator of WordSmith). This followed an email exchange I had with Mike Scott about my corpus and the fact that it consisted of a large amount of duplication, and my need to be able to distinguish duplicates and duplicate-producing texts from non-duplicate texts. To address this text reuse issue, Mike Scott created Duplicate Contents, which can be used to identify duplicates based on shared types and tokens between texts in a corpus. The Duplicate Contents tool and how it is used in this study will be discussed further in Section 3.4.

The second tool, Boilerplate Text, can be used to generate a list of the most frequent fixed sequences in a corpus, identified from the start of a sentence and at a length, to the nearest word, within a specified character range. This was developed to address the problem of analysing clusters in a corpus of texts consisting of highly formulaic language use and containing different amounts of text reuse. Clusters for such a corpus can potentially represent different overlapping segments of a small number of highly recurring long sequences, as was found to be the case with the staff replies corpus analysed in this thesis. The Boilerplate Text function addresses this problem by generating a list of coherent recurring sequences from the sentence boundary. How this tool is used in the present study will be discussed further in Section 3.7.

Another tool used in this thesis is CQPweb (Hardie, 2012). This is a web-based corpus analysis system developed and maintained by Andrew Hardie at Lancaster University. It contains a number of corpora, including the patient feedback to the NHS and the staff replies, the latter which are the focus of this thesis. It provides an interface for users to carry out a variety of corpus search and analysis tasks. In this study, I use CQPweb to identify keywords, collocates and concordances, which will be discussed further below.

CQPweb also contains metadata about the texts in the staff replies corpus, such as the type of service provider that produced them (e.g. dentist, GP practice) and the original patient feedback to which the replies relate. This analysis system includes options to restrict searches of the corpus based on the metadata. To do this with the original feedback, CQPweb allows for a subcorpus of the original feedback to be created, based on certain criteria, such as texts that contain a particular word, and includes a function where a staff replies subcorpus linked to this can be generated. Similarly, a subcorpus of the original patient feedback can be generated based on one of staff replies. This tool allows for patterns in staff replies that correspond with patterns in the patient feedback to those replies to be identified, and its application will be discussed further in Section 3.10 of this chapter.

In addition to being able to create subcorpora based on stored data, CQPweb also allows for a subcorpus of a corpus to be created by manually entering a list of filenames. In this way, a subcorpus created using other software can be generated in CQPweb. This has been a useful tool in the present study for combining the functionality of WordSmith 7 (i.e. the ability to

define a subcorpus based on whether it includes duplicates or not) and that of CQPweb where links to metadata can be made.

To move subcorpora created in WordSmith 7 to CQPweb, the spreadsheet software Microsoft Excel has been used. When Duplicate Contents is used in WordSmith 7, it produces a list of filenames of texts and their duplicates. To create a subcorpus of texts without duplicates or the duplicate-producing texts, this list can be copied and pasted into Excel along with a list of all filenames for a corpus, and filtered from the latter by highlighting all duplicates, sorting the list so that highlighted cells appear at the top and then deleting these. The final list can then be copied and pasted into CQPweb. The particular way WordSmith 7, CQPweb and Excel have been used in combination in this study will be discussed in Section 3.4.

3.3 Data overview

The data analysed in this study are staff replies to comments posted on the website NHS Choices by patients reviewing individual practices and hospitals across NHS England. While the primary focus of this study is on staff replies, I have also examined, at times, the original comments to these replies as part of my analysis. On occasion, the British National Corpus (BNC) has also been used as a general reference corpus to assess the typical usage of certain words.

The staff replies and original comments that relate to these were posted on NHS Choices between 2013 and 2015. These constitute an NHS Comments corpus provided as part of the 'Beyond the Checkbox' project (see Section 1.4). Information about the sizes of the staff replies and patient comments datasets that make up this corpus is displayed in Table 3.1.

Table 3.1 Sizes of comments and replies datasets

	Patient comments	Staff replies
Number of texts	228,113	128,929
Number of words	28,971,142	11,692,555

Staff replies are produced by representatives of individual NHS healthcare organisations which all have profiles on NHS Choices. Staff members at NHS practices or hospitals have the option to register with the NHS Choices website as 'comments administrator[s]', which

enables them to edit the profile of their organisation as well as to reply to patients' comments. Comments administrators receive email notifications when comments about their particular service have been posted on the website, allowing them to post a reply. The communication represented by staff posting replies to comments is limited to a two-turn exchange, meaning that after a staff member has replied there is no space for the patient to post a response to that reply. Based on the proportion of replies to comments in the data provided by the NHS to the CASS Centre at Lancaster University, 57% of comments posted on NHS Choices received a reply.

How staff reply to comments is at their discretion, though NHS Choices does include a page on its website for 'professionals' which provides advice about how to manage comments.[4] On this page is an FAQ section which includes the 'question': 'NHS Choices best practice tips'. These best practice tips are summarised as follows:

- 'Respond to all comments … It shows the commenter you listen'.
- To add a 'personal touch' and show that 'the practice is an open, welcoming place', respondents should provide their names.
- Avoid the use of stock replies as 'this looks worse than not responding at all'.
- '[A]nonymous comments' should be treated the same as 'named ones'. Staff should not automatically view anonymous comments as malicious. One way to deal with anonymous comments would be to suggest the commenter visit the practice in person to talk about the issues they have raised.
- Failure to remember a reported incident 'doesn't mean it didn't happen'.
- The fact that patients may be following the complaints procedure does not preclude them from also posting a comment.
- Members of the public read comments, so 'your reply is a good opportunity to market your practice'.

This advice offered to staff highlights the sense in which replies are viewed, by representatives of NHS Choices at least, as having an important relational function. This is suggested by the advice to personalise responses and to avoid viewing anonymous comments with suspicion, and is part of the reason for the use of discourse analysis methods that are

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[4] www.nhs.uk/about-the-nhs-website/professionals/pages/manage-feedback-faq.aspx.

particularly concerned with the relational function of language (see Section 3.9). A notable 'best practice tip' is the final one quoted above, which identifies the marketing opportunity represented by the situation of responding to online feedback. This proposal to engage in a commercial practice in a public service context partly accounts for the inclusion in this study of interdiscursivity as an analytic category (see Section 3.9).

One recommendation in the 'best practice tips' list is to avoid using stock replies in response to the comments posted by patients on NHS Choices. However, preliminary searches of the staff replies corpus revealed that this advice was often not heeded. Evidence of stock replies in the form of the same text being used multiple times was found to be widespread in the corpus. The implication of this for the use of corpus-assisted methods is that any patterns of language use identified may represent a single or small number of texts reproduced en masse. This would be contrary to the intended purpose of using corpus-based methods, which is to identify language use patterns across multiple different-authored texts, which would be the basis for making claims about a represented discourse.

Duplicates in the corpus pose a methodological problem that requires a method for separating duplicates from non-duplicates so that they do not skew findings when corpus methods are used. However, it is important to note that the issue of duplicates also raises an analytical opportunity to consider the contexts and purposes of staff use of duplicates, and the same when they use original replies, and what uses of language are associated with both. This is an opportunity taken in the present study which splits staff replies into different datasets based on their tendency to duplicate, and analyses these separately. The first part of this process is addressed in the next section.

3.4 Data preparation method

As mentioned above, in the present study, the discovery of a high volume of duplicates in the staff replies corpus has necessitated the removal of duplicates in order for corpus methods to be used without producing skewed results. However, as the duplicates in this corpus represent a practice of deliberate text reuse among staff – rather than, say, a data-processing error – they should not be discarded but used to constitute a separate dataset (along with the original texts identified as having duplicates). While it may not be possible to use traditional corpus methods such as keyword analysis to analyse duplicates, it is nevertheless necessary to carry

out some form of analysis on this new dataset if an account of the discourse of all staff replies is to be provided. However, a further complication arises from the fact that there is no clear-cut binary distinction between duplicate and non-duplicate staff replies, and that duplicates can vary in the degree to which they contain words from other replies. Therefore, the first stage of processing the data used in this study has been to develop a method for preparing the data so that it is suitable for analysis using corpus-based approaches.

The method developed has both a conceptual and practical component. Firstly, deliberate duplicates were conceptualised as discourse text types: 'stock replies' in the case of full-text duplicates, and 'mixed replies' when part of a reply represents reuse of text from another reply in the corpus. Non-duplicates were also conceptualised as a text type: 'unique replies'. The rationale for distinguishing duplicate and non-duplicate staff replies as different text types is that I expected them to involve different practices of production and the use of different language.

For example, reused replies might be more likely to consist of general formulaic language associated with a standardised way of saying something, hence their being termed 'stock' replies, so that they can be used to respond to more than one comment. Conversely, staff replies used only once might include individualised linguistic elements. As for replies consisting of a combination of reused and original text – what I refer to as 'mixed replies' – these are likely to consist of a mixture of the language expected in stock and unique replies, and to entail staff engaging in editing practices as they combine stock and unique elements.

After conceptualising duplicates and non-duplicates as three different discourse text types, it became clear that three separate datasets representing each of these text types needed to be created from the staff replies corpus. The reason for this was that the nature of the language use in each text type was distinct enough to merit separate analysis. To create these datasets, it was necessary to distinguish between texts based on degrees of similarity they shared with other texts in the staff replies corpus. For this purpose, as previously mentioned in Section 3.2, a corpus software tool, Duplicate Contents, was developed in WordSmith 7 by Mike Scott (2017).

Duplicate Contents is a tool that compares the number of words of each text with every other text in a corpus, using this as a basis for identifying duplicates. This comparison does not take

into account word order, so 'the patient was rude to the receptionist' would be treated as identical to 'the receptionist was rude to the patient'. The process used by Duplicate Contents is as follows:

> A rough check is first done, to see whether a chunk of a certain number of characters is found in each of the two text files under consideration. If so, word lists of each are computed, ignoring sections marked in angle-brackets. The frequency of each type is compared, giving any difference in tokens and types. If the differences in token frequencies or type frequencies are within the max words diff percentage, the pair are identified as near duplicates. (WordSmith Tools Manual, 2016)

The 'max words diff percentage' here refers to the function that enables users to specify a percentage of 'Maximum Difference', which refers to the amount of difference permitted between texts while still treating them as duplicates. In this way, it allows the user to identify part-duplicates. For example, by selecting a Maximum Difference of 10%, Duplicate Contents would identify as a duplicate not only texts that are completely identical to a text in the corpus, but also all those that are near-identical, allowing up to a 10% margin of difference. After identifying duplicates up to a Maximum Difference specified by the user, Duplicate Contents provides a list of filenames (each file representing a text) indicating texts and their duplicates. At this stage, users are given the option to move the duplicates to a new folder so as to separate them from the corpus.

To use Duplicate Contents to create datasets of the three discourse text types identified above – stock, mixed and unique replies – these text types were distinguished based on degrees of similarity. For 'stock replies', 95% was judged as an appropriate degree of similarity to allow for slight variations that might occur, such as the name of an addressee, between texts that are otherwise complete copies of each other. The stock replies dataset was thus created by uploading staff replies into Duplicate Contents and selecting a Maximum Difference of 5%.

As the option in Duplicate Contents is only to move duplicates to a new folder and not the original texts of which the duplicates represent copies (noting that these original texts are the same text type as the duplicates), the stock replies dataset was created manually. This was done by copying the list of filenames of texts and their duplicates generated in Duplicate Contents into Excel; using Excel to clean the list of additional text included in the Duplicate

Contents list so as to leave only the filenames; and then copying this 'clean' list into the corpus analysis system CQPweb which hosts a copy of the staff replies corpus and includes an option to create subcorpora by manually entering filenames. To be able to process this newly created stock replies dataset using other corpus tools (see Section 3.5), CQPweb includes an option to export the subcorpus as a .txt file.

The degree of similarity deemed appropriate for identifying 'unique replies' – texts that were likely originally written and that had no duplicates or part-duplicates – was 30%. This is based on previous research where similarity between texts above 30% was judged to be an indication of plagiarism (Olsson, 2004). To create this dataset, a similar process to that used to create the stock replies subcorpus was followed. However, after uploading staff replies into Duplicate Contents, the Maximum Difference selected was 70%, and rather than use the 'duplicates' (and the source of these duplicates) to create the dataset, all the non-duplicates were used instead. Therefore, the list of filenames in Excel based on the Duplicate Contents list was deleted from a filename list of all staff replies, with the remainder providing a list of 'unique replies' that was then uploaded into CQPweb to create the unique replies dataset.

To create the 'mixed replies' dataset, one option considered was to remove all stock and unique replies from the staff replies corpus and to use the remaining texts. However, the degree to which one staff reply matches another occurs on a cline, meaning that many texts in this version of a mixed replies subcorpus might be primarily stock or unique replies. This would be the case with staff replies that match other replies by slightly more than 30% or slightly less than 95%. Therefore, to create a dataset of replies with a more balanced mix of reused and original text, the replies that were included were those that matched other staff replies by more than 50% but not more than 70%.

This mixed replies subcorpus was created by processing all staff replies using Duplicate Contents to generate a list of duplicates (and the texts identified as having duplicates), based on a Maximum Difference of 30%. Using Excel, this list of filenames was removed from a list of all staff reply filenames to leave a list of staff replies minus those that match at least one other reply by more than 70%. Another copy of all staff replies was then processed using Duplicate Contents, this time based on a Maximum Difference of 50%. Again, the generated list of duplicates (and texts identified as having duplicates) was deleted from a list of all staff replies, this time to leave all replies where no reply matched another reply by more than 50%.

This second list was then deleted from the first to leave a list of replies which matched at least one other staff reply within a 51–70% range of similarity. As with stock and unique replies, the mixed replies dataset was then created from the list of filenames using CQPweb.

Three datasets were created as a result of following the above method. These are stock replies, unique replies and mixed replies, and the numbers of texts and words that constitute each dataset are displayed in Table 3.2.

Table 3.2 Size of reply type datasets (number of texts and words)

Reply type	Number of texts	Number of words
Stock replies	25,835	1,736,165
Unique replies	24,761	3,633,155
Mixed replies	22,907	1,580,455
Total	73,503	6,949,775

When added together, the total number of texts constituting the three datasets identified (73,503) comprise 57% of the 128,929 texts that make up the entire staff replies corpus. The relative proportions of these three datasets (when separated from the remaining 43% of staff replies not represented in these datasets) are illustrated in Figure 3.1 below.
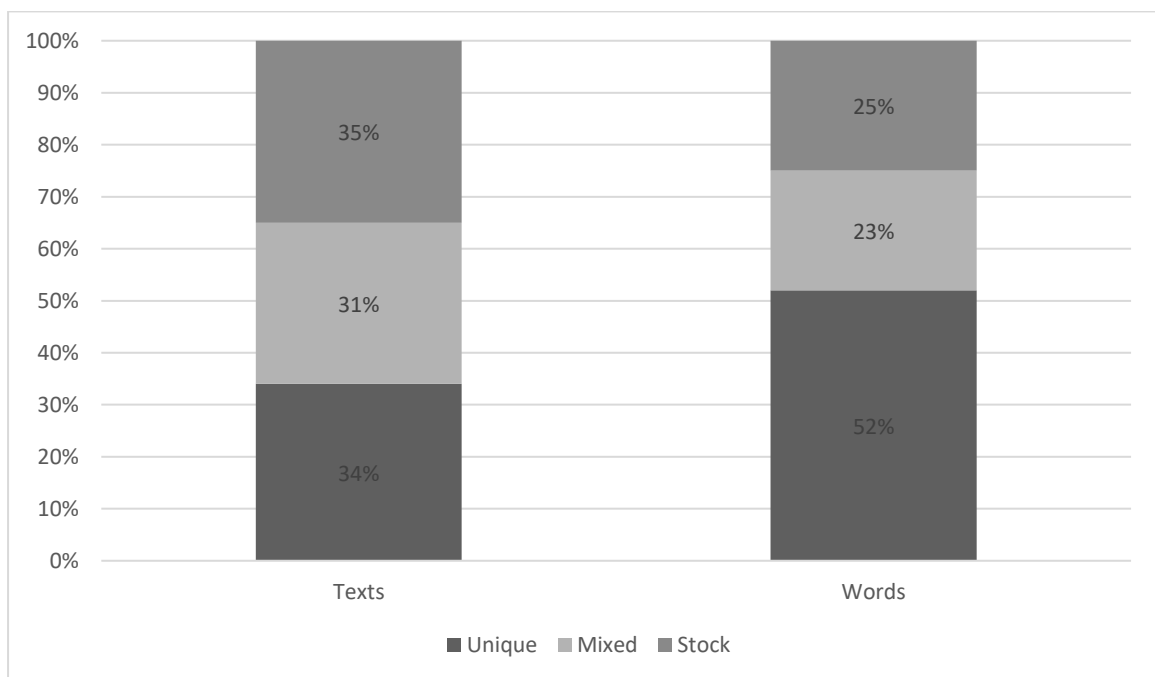
Figure 3.1 Percentages of unique, mixed and staff replies

The higher proportion of words in unique replies compared to stock and mixed replies, highlighted in Figure 3.1, indicates that overall this reply type tends to be longer than the others. This can be attributed to the fact that staff are likely to require more words when producing individualised responses to the specific details of feedback than when producing the more general messaging associated with text reuse.

3.5 A corpus-assisted discourse studies (CADS) approach

Having created the three datasets that form the primary focus of this study, a corpus-assisted discourse analysis (CADS) approach was used on each of them. This has entailed generally following the four stages outlined in Baker and McEnery (2015) – see Section 2.5.4 – though sometimes in a circular rather than linear manner when an initial CADS analysis gives rise to new lines of enquiry that initiate further CADS analysis (as described in Baker et al., 2008). An example of this is in Chapter 6, when a keyword analysis intended to provide an account of how language is used in the reply type under examination highlights a salient keyword, the word *unfortunately*, on which a concordance and collocation analysis is carried out to investigate what this word reveals about politeness practices in responses to patient feedback.

The four stages of analysis involve first using corpus techniques to identify and describe linguistic patterns in the data. The two main techniques for this purpose used in the present study are keywords and boilerplate chunks (repeated fixed word sequences); these are discussed, respectively, in Sections 3.6 and 3.7 following this section. The second stage involves interpreting the linguistic patterns identified, which can be supported by the use of other corpus techniques, such as collocates and concordances, discussed in Section 3.8, or text sampling, discussed in Section 3.9.

The third stage entails explaining the patterns of language use identified. For this, contextual information needs to be drawn on, which includes existing knowledge, or that acquired from a review of literature, about the NHS and the purpose of patient feedback (see Sections 1.4 and 2.3.1, respectively); certain social trends such as public service marketisation (see Section 1.5.3) and online review practices (see Section 2.3.1); and information about the interactional context of replies, as provided by metadata and the original patient feedback which the NHS replies were made to (see Section 3.10). The final stage involves making critical observations where these may be warranted, such as when identified linguistic

patterns indicate discourse practices that are seemingly at odds with an expected purpose of staff language use when they produce replies to patient feedback.

The corpus-assisted nature of the approach used in this study means that the analysis sometimes includes a qualitative analysis of sample texts where corpus techniques may not have been employed. In these instances, the identification, description and interpretation of linguistic patterns have been guided by a variety of discourse analytical categories, particularly ones relevant to the interpersonal function of language, a major focus of this thesis. These have also been applied in the second 'interpretive' stage when CADS has been used.

The discourse analytical categories drawn on in the analysis of staff replies include several that are especially useful for addressing RQ2 (*How do linguistic choices position staff, patients and the relationship between them, and how does this relate to the concept of patient-centred care?*). This is because they relate to the interpersonal aspects of language use. They include politeness and impoliteness, and how these relate to face needs and threats (see Section 2.4), and speaker address – that is, how linguistic choices can position audiences (see Section 2.3.1 and reference to Vasquez, 2014).

Other discourse analytical categories drawn on are more relevant to RQ3 (*How does staff use of language reflect different discourses in terms of (a) register and (b) ways of viewing the world, and how do these relate to patient-centred care?*). These include interdiscursivity, in particular that which involves discourse marketisation (see Sections 1.5.3 and 2.6); register (see Section 2.4.1); and genre moves (see Section 2.3.2).

3.6 Keywords: unique and mixed replies

In this section, I will describe the keyword analysis method used on two of the datasets examined in this thesis: unique and mixed replies. As already observed in Chapter 2, keywords are words that occur more often in one corpus when compared against a second 'reference' corpus. They are identified using statistical tests and can provide a starting point for analysing the language use or discourse represented by a corpus. An analysis of keywords can reveal linguistic patterns that we can claim to be characteristic of a represented language use or discourse. While groups of keywords help to provide a general account of a language

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use or discourse, individual keywords can provide greater insights through a closer analysis of those keywords judged to be particularly salient.

To calculate keywords in this study, the unique replies dataset was compared to a reference corpus consisting of the stock and mixed replies, and the mixed replies dataset was compared to a reference corpus consisting of the stock and unique replies. The rationale for using the other datasets as the reference corpus is that they help to highlight features that distinguish staff replies as particular reply types.

Keywords were calculated using the keyword tool in CQPweb. The keywords of unique replies were calculated using the statistical measure Log-likelihood with a significance cut-off of 0.01% and a minimum frequency of 3 in both the target and reference corpus wordlists. Using Log-likelihood to calculate keywords is an established approach, as reflected by the fact that it has long been included as the default measure in tools like WordSmith and AntConc.

Log-likelihood is a hypothesis-testing measure based on statistical significance. It measures the confidence with which something can be said to be a keyword. This measure tends to favour higher-frequency words because there is more evidence that a difference exists when a high-frequency word is examined across two corpora. However, Log-likelihood does not prioritise very large or strong differences, so it can produce keywords that may occur 1,200 times in one corpus and 1,000 times in another (equal-sized corpus). While the relative difference may be quite small, we can at least be confident that there is a difference (Gabrielatos, 2018).

Although the same cut-offs were used to calculate the mixed reply keywords (i.e. a significance cut-off of 0.01% and a minimum frequency of 3), the statistical measure used was Log Ratio. Log Ratio can produce lower-frequency keywords where the relative differences are very high (Hardie, 2012). The reason for this change in statistical measure is because of the tendency of Log-likelihood to generate keywords that are highly frequent. The higher the frequency of keywords, the more representative they are likely to be, which is why Log-likelihood is used on unique replies. However, in the case of mixed replies, which partly consist of reused text, keywords with a higher frequency are more likely to originate from the reused parts of replies.

This was indicated by a search of mixed reply keywords using Log-likelihood, where the three words identified as being most key were *your*, *thank* and *taking*: the kind of words that occur as part of a formulaic politeness string at the start of texts (e.g. *Thank you for taking the time to post your comments*) and are therefore likely to represent the reused text parts of mixed replies. As keywords are only meaningful for analysing language use or discourse insofar as they reflect individual choices, Log Ratio was used on mixed replies, where results indicate that keywords are less likely to come from the reused text. The reason for not using the same on unique replies was because higher-frequency keywords are more widely representative of the language contained in a corpus and so using Log-likelihood seems preferable when the data being analysed is suited to such a measure.

The use of different statistical measures to calculate the unique and mixed reply keywords prevents a direct comparison being made between the keyword findings of each dataset. However, this difference is consistent with the fact that all three datasets examined in this thesis involve the use of tailored methods that reflect the nature of the reply type represented by each subcorpus. In this respect, none of the reply types are amenable to direct comparison between like-for-like results, a situation created by the effects of text reuse and, therefore, the need to use different method designs (see Section 3.4). Therefore, any comparisons between the reply types are based on general findings from the analysis rather than specific individual results.

Once generated, the lists of keywords for unique and mixed replies were filtered to remove proper nouns and numbers, as an initial analysis of these items found that they were not pertinent to the study, and then the top 50 keywords were grouped into themes or grammatical categories. The purpose of this was to highlight any patterns across the keywords that could help provide a general account of the represented discourse, as well as to frame a closer focus on any salient keywords. As keywords provide a starting point in the analysis of staff language use, they can be used to create concordances or inform the selection of text samples for closer analysis (parts of the corpus-assisted discourse analysis method used in this study that are described later in the chapter).

Keywords are not limited to use at the outset of a corpus-assisted study. They can also occur as part of an iterative process of analysis, which was the case with both the unique replies and mixed replies datasets. In the case of unique replies (see Section 6.4), two subsets of staff

replies were created, based on two keywords, with all unique replies that included one of the keywords (*new*) making up one of the subsets, and all containing the other keyword (*demand*) making up the other.

These subsets of data were then, in turn, compared to a reference corpus consisting of all the other unique replies to calculate further sets of keywords (30 for each – a smaller, more manageable number than used initially, which is appropriate given the smaller and more specific data involved). The reason for creating these data subsets was because the two keywords on which they were based have been interpreted as indexing particular discourses. The purpose of the analysis of the keywords of these subsets, therefore, was to identify any linguistic patterns that may corroborate the interpretation of the initial two keywords as discourse-indicating.

With mixed replies (see Section 7.2), a further keyword analysis was carried out to control for the influence of situational factors highlighted following the analysis of the initial set of keywords. These factors are the disproportionate amount of mixed replies occurring in a particular service area and in response to a particular evaluative stance of patients, when compared to the replies that constitute the reference corpus. Therefore, the second set of keywords was calculated by including only mixed replies from one service area and in response to one evaluative stance – the same for both the target and reference corpus. The findings from this second set of keywords supplement the findings from the first set.

In this study, keyword analysis was used on the unique replies and mixed replies datasets but not on the stock replies dataset. The reason for this was because the stock replies dataset includes a high volume of reused texts, meaning that generated keywords may represent language from replies that have been copied and pasted multiple times. Keywords obtained from the stock replies subcorpus tended to be those that were contained in stock replies that had been reused many times and thus only reflected a small proportion of the most frequently copied messages. In this way, keywords of stock replies might only represent language use choices at a text level and not a discourse level.

A similar charge could be levelled at mixed replies, which partly consist of reused text. However, all mixed replies are texts that are in some way distinguishable from every other text in the staff replies corpus, which means that each mixed reply text has involved some

level of choice being made about the language used. Therefore, with mixed replies, even if keywords originate from reused text, every instance of their occurrence can be viewed as a choice to insert or not to edit or remove the reused text in which they occur. This is not the case with stock replies that have been copied and pasted, sometimes en masse.

3.7 Repeated word sequence frequency: stock replies

The unsuitability of a keyword analysis on stock replies, as described in the previous section, is not only due to the high volume of duplicates in the dataset. It is also due to the highly formulaic language used. This was highlighted by generating keywords of stock replies using single occurrences of different stock texts. The strongest keywords – based on using Log-likelihood and unique replies as a reference corpus – included *thank*, *your*, *comments*, *kind* and *taking*, words that tend to form part of ritualised politeness routines associated with the openings of formal written responses.

On this evidence, stock reply keywords appear to represent the kind of words that constitute a single sequence rather than a group of individual words that have distinctly different meanings and functions. Therefore, the word, as used in keyword approaches, does not represent a suitable unit of analysis for highly formulaic texts like stock replies. Instead, the unit of analysis used on stock replies in this study was the word sequence.

One way of identifying repeated word sequences in a corpus is to select a size of sequence (i.e. *n*-grams) or a range of sizes, and to use software to highlight the most frequent. This can be done by using the 'clusters' tool in WordSmith 7. However, an initial search of *6*-grams in stock replies revealed how this approach can be problematic with a corpus containing highly formulaic language and a large amount of text reuse. The most frequent *6*-grams identified were found to represent different overlapping parts of the same few longer clusters. This means that a list of apparently different results can prove to be the same single result, making this an unsuitable method of analysis for the data.

To address this problem, the corpus software tool 'Boilerplate Text' was developed in WordSmith 7 by Mike Scott (2017). This tool identifies sequences within a specified character range from the sentence boundary (where a capital letter follows sentence-ending punctuation), which helps to produce coherent sequence results and to filter out the 'noise' in

the data created by overlapping sequence fragments. Although this method focuses on repeated word sequences that occur from the start of sentences (hereafter referred to as 'boilerplate chunks'), with highly formulaic texts like stock replies this still results in representative findings (as confirmed by a comparison of random text samples with a list of results). Therefore, instead of the keywords used with the other two datasets, the identification of the most frequent boilerplate chunks is used as a starting point for the analysis of stock replies.

In this study, stock replies included in the analysis are only those that contain 20 or more words. This accounts for 85% of stock replies. The reason for this cut-off is to exclude very short texts that repeat because of coincidence rather than deliberate text reuse, which is a basis of the characterisation of this text type as stock replies.

To produce representative results, three subsets of data were created from stock replies based on the three main service areas in which they occur – GP practices, Dentists and Hospitals (which account for 96% of replies). These were each further divided into 'positive' and 'negative' datasets based on linking replies to the evaluative stance of original patient comments, where evidence of this is available. The latter was provided by the fact that many patients, when leaving comments on NHS Choices, also completed a questionnaire. The evaluative stance of original comments – negative or positive – was determined by responses to a question about how likely the commenter is to recommend a service to friends and family. When compiling the data subsets based on evaluation, the responses 'extremely likely' and 'likely' were treated as positive, and the responses 'extremely unlikely' and 'unlikely' as negative.

After creating the six stock reply datasets, the 20 most frequent boilerplate chunks in each set were calculated in WordSmith 7. The sizes of boilerplate chunks identified were those within a range of a minimum of 15 and maximum of 400 characters, which resulted in sequences ranging from three to seven words in length. The boilerplate chunks were then grouped into categories based on their discourse function, which provided the basis for analysing how language is used in stock replies and the different language choices available to serve particular discourse functions.

3.8 Concordances and collocates: primarily unique replies

While keywords and boilerplate chunks provide starting points for analysing the datasets in the present study, the corpus-based methods described in this section represent a secondary stage of analysis. As noted in Section 2.5.4, concordances and collocates are methods for considering the kind of words that a word of interest tends to occur with. As a list of lines displaying each instance of a selected word with the words that immediately occur to its left and right in the corpus, concordances provide a means of reviewing the use of a word and making inferences about its meaning and function based on multiple examples of its surrounding text. Collocates provide a way of identifying the meaning of a word based on the words with which it tends to co-occur at a statistically significant rate; this includes revealing any implicit meanings a word may have.

In this study, reviewing concordances and the analysis of collocates were primary methods used on unique replies. These methods were also used on the other datasets to clarify meanings of words as required, but they did not entail a systematic analysis of the data as was the case with their use on unique replies. The reason for this is because a keyword analysis was carried out on unique replies, and the use of concordances and collocates to analyse salient keywords helps to link single lexical items to the discourse in which they occur and might be said to represent. Keywords were not calculated for stock replies, which means they do not provide the same justification for using concordances and collocates on this dataset. As for mixed replies, keywords were used, but because of the particular nature of this reply type, a different method for closer examination of the language of mixed replies was favoured instead of the systematic analysis of concordances and collocates (see Section 3.9).

The method for analysing concordances of words of interest from unique replies entailed searching individual words using the 'standard query' field in the web-based corpus analysis system CQPweb. This automatically generated a list of concordances which were randomised by selecting the option 'show in random order'. A selection of 100 concordances (or slightly more when there is a particular sampling rationale – see Section 3.9) was reviewed and inferences about the meaning and function, or purpose, of the searched lexical items were used to create categories to represent the different ways the search term is used in unique replies.

The number of times the term represents a particular category was then counted for the purpose of quantifying how the searched lexical item tends to be used in the corpus. The different categories and quantitative results were then used to direct the selection of sample concordances for closer analysis. This was with a view to providing an account of how the analysed word(s) of interest constituted a distinct feature of the use of language represented by the unique replies dataset.

The method used for analysing collocates of words of interest (e.g. keywords) from the unique replies dataset similarly used CQPweb, where an option to search collocates is available via the concordances page. Collocates were searched using the effect size statistical measure Mutual Information (MI), a collocation window of three words either side of the searched item and the requirement that collocates occur a minimum of five times. The choice to use MI to calculate collocates is based on its tendency to generate lexical words, which complements the view of grammatical patterns already provided by a concordance analysis where collocates are primarily used in this study (see Section 6.3). Additionally, the use of MI produced results of interest, generating collocates that corroborate findings from the concordance analysis while also providing further insights about the discourse under examination. After generating a list of collocates, the top 30 were then grouped into thematic categories, and these themes and individual collocates were used to analyse the meaning of the word of interest, in particular regarding what this meaning could be said to reveal about the discourse of unique replies.

3.9 Text sampling

The analysis of all three datasets presented in this thesis entailed some form of text sampling. This was both for the purpose of using corpus-assisted methods and for carrying out qualitative analysis. In some cases, selecting texts at random represents the most appropriate approach to sampling. This was the method used on stock replies where 50 stock replies were selected at random for an analysis of language use. The texts were selected by scrolling through an Excel list of the filenames of all stock replies and randomly highlighting 50 of these. The purpose of this qualitative analysis of a random sample was to investigate evidence of relational aspects of staff language use in stock replies, specifically with respect to the theme of personalisation. The findings from this qualitative analysis could then be triangulated with the findings from the analysis of repeated word sequences (boilerplate

chunks) to provide a more complete account of how staff use language when they produce stock replies.

With other text sampling in the study, random selection was not an appropriate approach as samples were required on the basis that they would illustrate certain language behaviour that is highly unlikely to be found in texts selected at random. This was the case with sampling mixed replies for the purposes of analysing variation between texts that share common reused elements. One expectation about mixed replies was that they would represent stock replies that have been modified, and such modifications could provide evidence of practices and choices that are characteristic of the language of healthcare staff when they respond to online feedback. This was why a systematic analysis of concordances and collocates did not follow the keyword analysis of mixed replies; that is, because space for a close analysis of this dataset was determined to be better used to analyse variation instead. However, to analyse variation between mixed replies, it was necessary to identify sample texts that share the same reused elements.

To analyse variation between mixed replies, a sample was created by identifying pairs of mixed replies that share the same reused elements alongside different elements. These different elements represent variation, as might result from staff respondents making changes to stock text. To increase the likelihood of identifying linked reply pairs that share common reused text, texts in a pair were selected from the same practice or hospital. In this way, texts in a pair were more likely to share the same original elements, relative to which the differences between the texts would represent particular language use choices.

The sample text pairs selected for the analysis of variation between mixed replies were all taken from GP practice replies (only GP practices are used so as to control for variation caused by service area differences). The top 50 GP practices with the most replies provided the source of the sample pairs: the greater the number of texts, the greater the likelihood of identifying samples. One pair from each of the top 50 different GP practices was selected to make any identified variation patterns more generalisable and not just attributable to one GP practice or individual staff member.

The method used to identify the sample pairs was as follows: a list of mixed reply filenames was cross-referenced with a list of all reply filenames from the top 50 GP practice replies. All

occurrences shared between the lists were highlighted and, using Excel, a new list of mixed replies for the top 50 GP practice replies was created. This list was then cross-referenced with the Duplicate Contents list with a Maximum Difference of 50% that was used in the creation of the mixed replies dataset (see Section 3.4).

The purpose of this was to highlight mixed replies from the top 50 GP practices in the Duplicate Contents list: where these mixed replies occurred on the Duplicate Contents list in the same grouping (i.e. a group of duplicates and the text identified as having those duplicates), these were likely to represent mixed reply texts with the same common elements, and therefore the required sample pairs. A review of the texts confirmed that the texts were pairs that shared the same common elements. Pairs for each of the top 50 GP practices were then selected to create the sample.

Another non-random sampling method in this study was used on unique replies when texts for a sample were selected on the basis that they contain lexical items that provide evidence of a particular language use practice. The lexical items were not keywords; they were words of interest based on speculative searches in the corpus of the kind of words that would be expected to be used as part of the practice in question. The practice itself was the use of third-person naming strategies by staff to refer to commenters when responding to their feedback (see Section 6.5).

Though these strategies were revealed by a keyword analysis of unique replies, the single keyword did not represent a practice that can be linguistically realised in a variety of ways. Therefore, a combination of existing familiarity with the language use of unique replies and speculation was used to compile a list of commenter-referring third-person forms. These third-person forms were then used as search items to create a dataset consisting of unique replies in which any of the search items occurred. Concordances of the third-person forms were then analysed; these concordances were randomly selected (using CQPweb's 'show in random order' function), and a concordance sample representing 10% of texts in which each form occurred was used.

3.10 Linked data

While analysing the language of healthcare staff is the main focus of other methods described in this chapter, the method presented in this section involves analysing staff replies in terms of linked data. This data includes information about the service area in which staff replies were produced, score ratings provided by commenters who completed questionnaires as well as leaving free-text feedback and the language of original comments.

The three staff reply datasets analysed in this study are each quantified in terms of the first two of these types of data in Chapter 4. The purpose of this chapter is to consider the influence of situational factors, namely service area and evaluative stance of original comments, on how staff respond to online patient feedback; or more specifically, to investigate whether certain reply types tend to be used more or less often in particular service areas and in response to comments based on whether they are positive or negative.

The method used to quantify the different reply types in terms of service area was to cross-reference a list of the filenames of each reply type (i.e. stock, unique and mixed) with a list of staff replies divided based on service area. This was done using Excel. Items that occurred in both lists were used to constitute new lists of each reply type divided into different service areas. The quantities of replies in each service area for each reply type were then identified and were available for analysis.

The method used to quantify the reply types in terms of evaluation similarly entailed cross-referencing lists: those of the reply types with those of replies based on evaluation. To create the latter, CQPweb was used to generate lists of patient comments based on commenters' responses to a questionnaire question (in instances where the questionnaire had been completed). Negative and positive comments were determined by identifying how commenters responded to the question about how likely they were to recommend a service to friends and family: the responses 'extremely likely' and 'likely' were treated as positive, and the responses 'extremely unlikely' and 'unlikely' as negative.

When lists of positive and negative comments had been generated, a tool in CQPweb (specifically created by Andrew Hardie at Lancaster University for this purpose) was used to generate lists of replies linked to these comments. Lists of 'positive' and 'negative' replies

were then copied into Excel to cross-reference with lists of the different reply types. New lists of reply types were then created based on where filenames occur in both lists. The quantities of replies to positive comments and replies to negative comments for each reply type were then identified and were available for analysis.

As well as quantifying how reply text types link to service area and whether staff are responding to negative or positive feedback, this study also considers the language of staff replies relative to the language of original comments. Reviewing the language of original comments forms part of the analysis of all three reply types, as and when the interactional context of staff language is particularly pertinent to the analysis at hand. However, a comprehensive analysis of the language of staff replies relative to the language of patient comments is not permitted within the scope of this study. The original comments were included as part of a systematic analysis of staff replies when analysing stock replies as part of an investigation of compatibility between stock replies and original comments (Section 5.5). The rationale for this investigation was that there is an increased likelihood of comment–reply mismatch with replies produced en masse, as can be the case with stock replies.

The method used to investigate mismatching in this study is as follows: evaluative words (those that likely indicate replies recapping the evaluation of comments) were identified from the list of most frequent words in stock replies. Using CQPweb, reply datasets were created using these evaluative words, and datasets of original comments linked to these replies generated. Lists of the original comments datasets were cross-referenced with lists of positive and negative comments (previously used above). The purpose of this was to highlight any instances where original comments provided a score rating at odds with the evaluative word used in reply to comments. Highlighted mismatches between score rating and recapped evaluation words used in response were then investigated more closely, with comments and replies reviewed to establish whether these were genuine mismatches (i.e. not simply an apparently positive evaluative word occurring with a negative modifier) as well as the nature of the mismatch (i.e. whether staff use of the evaluative word was completely or only partially at odds with the evaluation represented in a comment).

3.11 Conclusion

The main purpose of the methods presented in this chapter is to facilitate an analysis of staff replies in a way that addresses the thesis aims and research questions. The use of a corpus-assisted discourse analysis approach means that many of the methods used in this study are inductive, where emergent findings from the use of frequency and statistical measures form the basis for analysing discourse and language use. In this way, a general account of how healthcare staff use language, when responding to online feedback, can be derived from statistically meaningful distinctive patterns identified across a large body of texts. This helps to avoid the risk of the analyst being drawn to language features in texts because they confirm existing expectations about the language use of healthcare staff.

In addition to using traditional corpus methods such as keyword and concordance analysis, this thesis also includes the qualitative analysis of text samples. This approach is used to triangulate corpus-assisted findings with a qualitative analysis of text samples for the purpose of providing a nuanced account of how healthcare staff use language. It is also used to identify and analyse language features for which an automated corpus-based method does not currently exist, as has been the case with analysing variation between mixed replies with shared reused text (see Section 3.9).

Corpus-assisted methods can be dynamic and iterative: dynamic in the sense that corpus processing techniques can be combined with qualitative analysis in different ways depending on the nature of the data and purpose of the researcher; and iterative in that they can involve moving between the generation, analysis and interpretation of results, as part of a cyclical process driven by emergent findings. The implication of the dynamic and iterative aspects of a corpus-assisted approach is that they prevent the creation of a comprehensive method design at the outset of a study. It is for this reason that, while well-established corpus methods (e.g. keyword and concordance analysis) are presented in this chapter, it also includes more idiosyncratic methods which emerged after an initial analysis of the data.

A further feature of corpus-assisted methods is that they are in an ongoing state of evolution, owing in part to the role of software that is continuously being developed, the employment of new statistical measures and the dynamic nature of the method which allows for innovation in method design. In this respect, corpus-assisted methods often do not only entail the reuse of

existing models but can also require the development of new tools and techniques, and new forms of corpus data can require new approaches. This has been the case with the present study, where the high number of duplicates in the data has necessitated dividing the staff replies corpus into three more manageable datasets (see Section 3.4). It has also required choosing methods best suited to the different nature of the texts represented by each of these datasets, as have been presented in this chapter.

Chapter 4: The Influence of Service Area and Evaluation on Reply Type

4.1 Introduction

This chapter looks at how the three datasets that are the focus of this study, each representing a different type of staff reply to patient feedback (i.e. stock, unique and mixed), link to two kinds of metadata: the service area in which staff have chosen to use particular reply types and whether original comments are negative or positive. The aim of the chapter is to identify preferences for different reply types based on service area and the evaluative position of patient comments, and to consider the extent to which reply types are preferred because of these two factors. Overall, the purpose of the findings presented here is to provide some contextualising information about the text production tendencies of healthcare staff, to be drawn on where relevant in the linguistic analysis of staff replies in Chapters 5, 6 and 7 that follows this chapter.

The chapter is divided into three main sections. Section 4.2 looks at how much the different text types are used by staff from different service areas. Section 4.3 looks at how much the different text types are used in response to comments based on whether they are positive or negative. Section 4.4 looks at where tendencies associated with service area and the evaluative position of comments overlap. Finally, the conclusion in Section 4.5 reflects on ways in which the findings in this chapter can be useful for providing important contextual information in a study that analyses discourse.

4.2 Linking choice of reply type to service area

Staff replies originate from nine NHS service areas: Acute trusts, Care providers, Clinics, Dentists, GP practices, Hospitals, Mental health trusts, Opticians and Pharmacies. As the majority of replies (96%) come from Hospitals, GP practices and Dentists, this section focuses exclusively on these three service areas.

To consider the link between service area and reply type, lists of the reply type texts were divided into the three main service areas. The number of each reply type in each service area is displayed in Table 4.1 below.

Table 4.1 Number of replies from different service areas divided by reply type

	Hospitals	GP practices	Dentists
Stock replies	8,500	7,761	8,673
Unique replies	4,775	16,185	2,506
Mixed replies	10,533	9,065	2,421
Total	23,808	33,011	13,600

The total number of texts representing the different reply types varies considerably across service area. For example, GP practices produce nearly 20,000 more replies than Dentists. For this reason, the number of each reply type is represented, in Figure 4.1, as a percentage of the total number of texts for all the reply types in each service area. This provides a representation of the proportions of the reply types for each service area.
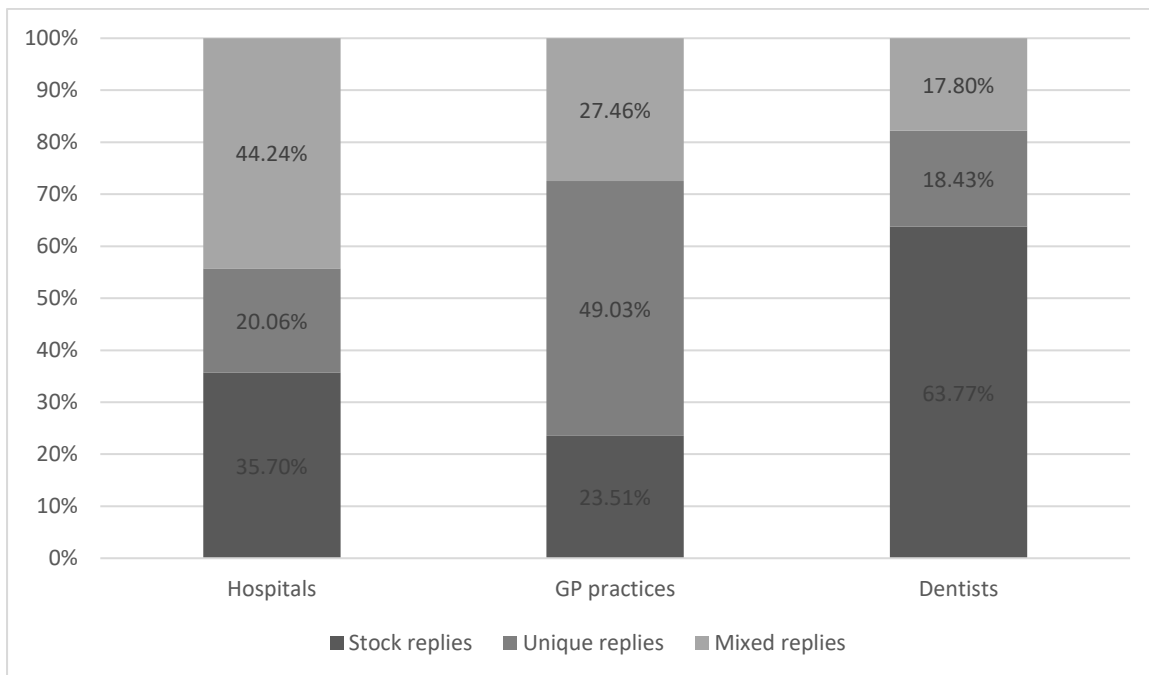
Figure 4.1 The proportions of reply types produced in the three main service areas

A pattern that emerges from Figure 4.1 is that each service area has a different text type preference. Most notably, Dentist staff appear to prefer to give stock replies over three times as often as unique replies, which occur less than 20% of the time and are similarly as infrequent as mixed replies. The favoured text type of GP practices, unique replies, is not as dominant a choice, though they are still used in almost half of instances by staff. As with Dentists, the non-preferred reply type choices occur at a similar rate, though there is a clearer

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preference for mixed replies over stock replies among staff in GP practices. Mixed replies represent the preferred reply type of Hospital staff, followed by stock and then unique replies. A strong second preference is shown with Hospital staff but not in the other service areas. This highlights the fact that, though mixed replies represent the preferred reply type, overall Hospital staff favour using replies that contain reused text, which comprise 80% of Hospital replies that produce the three reply types identified (the proportion that are mixed and stock replies).

Possible explanations for the reply type preferences of different service areas are suggested as follows. With Dentists, the strong preference for stock replies could be explained by the fact that many practices are part of larger businesses, such as MyDentist, which provide both private and NHS services. The commercial ethos of such Dentist services might influence staff to choose time-saving (and therefore also cost-saving) measures over concerns about patient engagement, hence the high proportion of stock replies produced in this service area.

The preference of GP practices to use individually written (unique) replies might be attributed to their tendency to be situated in local communities and to involve more personal ongoing relationships between patients and their local surgeries. As for Hospitals, the reason for staff favouring replies based on reused text might be due to standardisation as can occur with the management of larger organisations like hospitals. The particular preference in this service area for mixed replies could be explained by the fact that hospital visits more typically involve very personal experiences, such as serious illness or births, which may compel staff to personalise the standardised stock replies that might otherwise be used.

As well as the preferences revealed by identifying the proportions of different reply types in each service area, it is worth considering how the reply types are divided between the three main service areas, as illustrated in Figure 4.2 below.
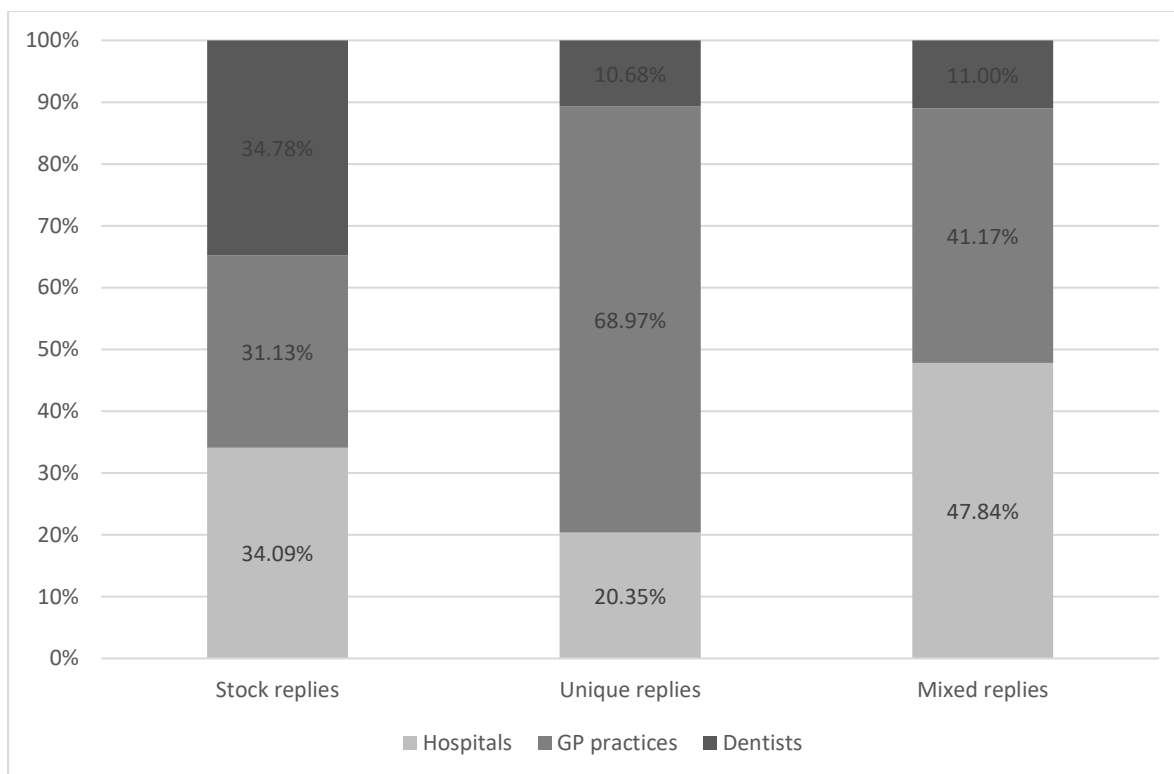
Figure 4.2 The proportions of reply types based on service area

Representing how reply types divide into the three main service areas illustrates that a similar volume of stock replies occurs in each service area, particularly between Hospitals and Dentists. Therefore, although this reply type might be most preferred by Dentist staff, it occurs almost as frequently in both of the other service areas. This shows how the use of stock replies is common practice across NHS services.

In Figure 4.1, GP practices were shown to use unique replies almost 50% of the time when producing the identified reply types. However, the higher number of GP practice replies overall (see Table 4.1) means that over two-thirds of unique replies are produced in this service area. This highlights how the majority of individually written replies are produced by GP practice staff, and therefore supports explanations based on service area when considering reasons why staff produce unique replies.

4.3 Linking choice of reply type to evaluative position of original comments

When people post feedback on the website NHS Choices, they are also given the option to complete a questionnaire. This questionnaire uses a Likert scale with respondents offered a

choice of prepopulated answers to reply to a series of statements and questions. One of these questions asks how likely the respondent is to recommend a service to friends and family. As with all the questions, the choice of answers is as follows (linked scores are included in brackets): extremely likely (5), likely (4), neither likely nor unlikely (3), unlikely (2) and extremely unlikely (1). As this question elicits an overall rating of a service, with answers provided in the form of number scores, the results can be used to represent the evaluative position of the linked written feedback. The evaluative position of feedback can then also be linked to staff replies to feedback, and specifically to different types of staff reply, as is done in this section.

Linking staff reply types to the evaluative position of patient feedback is useful for identifying if, and to what extent, evaluation influences staff to use a particular reply type when responding to feedback. For the purposes of this study, evaluative position has been simplified so that it refers only to whether feedback can be said to be positive or negative. This is calculated by treating all feedback that included an 'extremely likely' or 'likely' response to the 'family and friends' question as positive, and all feedback that included an 'extremely unlikely' or 'unlikely' response as negative. Of the 70,419 texts that constitute the three reply types for the three main service areas, 53,235 (76%) can be linked to original comments that are clearly positive or negative, based on using this method. The numbers of texts used to respond to positive and negative comments for each reply type are displayed in Table 4.2 below.

Table 4.2 Numbers of reply types relative to evaluative position of original comments

	Stock	Unique	Mixed
Positive	12,168	5,392	13,403
Negative	5,326	12,332	4,614
Total	17,494	17,724	18,017

The numbers in Table 4.2 are represented as percentages in Figure 4.3 to illustrate the proportion of positive to negative comments that receive each of the different reply types. The horizontal line in Figure 4.3 marks the proportion of positive to negative comments overall (based on instances in the 29-million-word corpus of feedback where a clear positive or negative response to the 'family and friends' question has been provided). Above the line

represents the total proportion of positive comments (58%), and below the line the proportion of negative comments (42%).
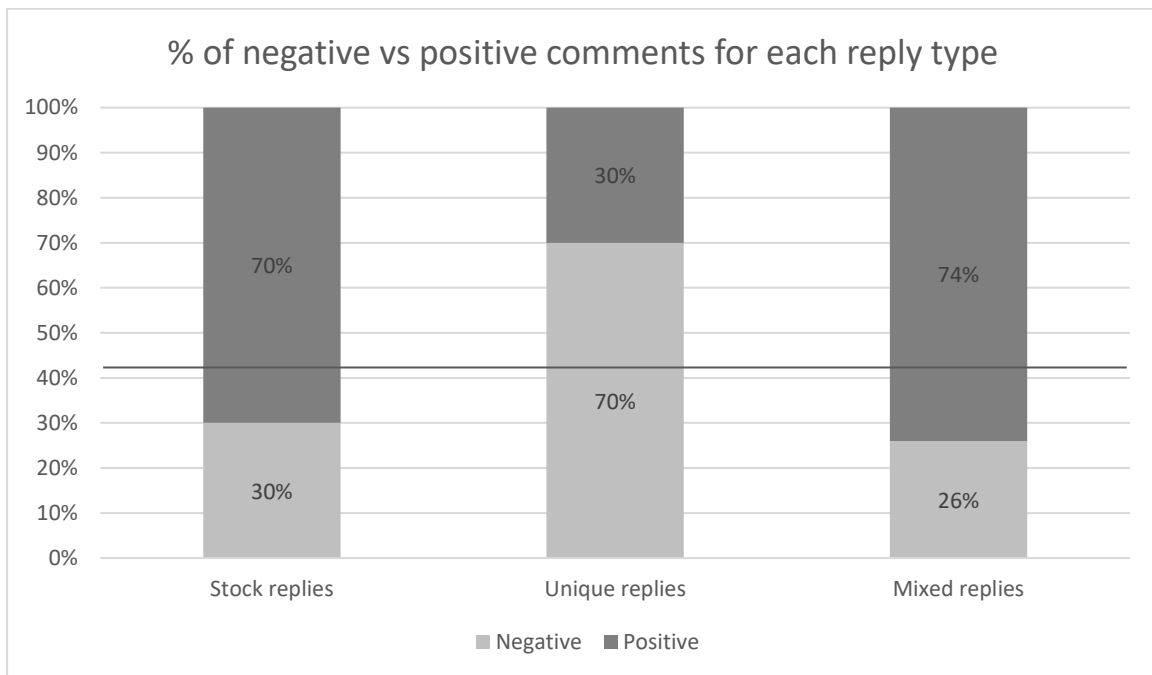
Figure 4.3 The percentage of negative versus positive comments linked to each reply type

The results in Figure 4.3 show that stock and mixed replies are used more to respond to positive than negative comments, 12% and 16% higher, respectively, than the rate at which positive feedback occurs (as indicated by the horizontal line). In contrast, unique replies are used more to respond to negative comments, at a rate 28% higher than that at which negative feedback occurs. The tendency of unique replies to be used in response to negative feedback is double that of mixed and stock replies (based on averaging the two) when these are used to respond to positive feedback. This suggests that the evaluative position of comments is a particularly strong factor in determining staff use of unique replies.

A possible explanation for the greater tendency of unique replies to be used in response to negative feedback is that staff may be more likely to feel the need to individually address complaints. Staff engaging with the specific details of patients' reported negative experiences might occur as part of relationship repair work or used in counter-arguments to criticism to manage public image. These functions are not required when feedback is positive and staff might feel that generic expressions of gratitude will suffice. This would explain the greater tendency of stock and mixed replies to be used in response to positive feedback. The

preference for using mixed replies in response to positive feedback can also be explained by the fact that staff may wish to personalise a generic response to praise, particularly when it has been especially friendly or flattering.

4.4 Linking choice of reply type to service area and evaluative position

Having considered in Section 4.2 the link between service area and reply type, and in Section 4.3 the link between the evaluative position of comments and reply type, this section will examine how these two influences on reply type choice overlap. The aim is to investigate whether preferences for using different reply types in response to negative or positive comments vary between service areas.

To this end, the reply type datasets previously divided into the three main service areas were further divided based on whether they responded to positive or negative feedback (using the method from the previous section). The numbers of texts for each reply type, divided into service area, are represented in Figure 4.4 below. In this figure, columns indicating the number of service area replies for each of the reply types also represent the negative–positive proportion of original comments linked to these replies.
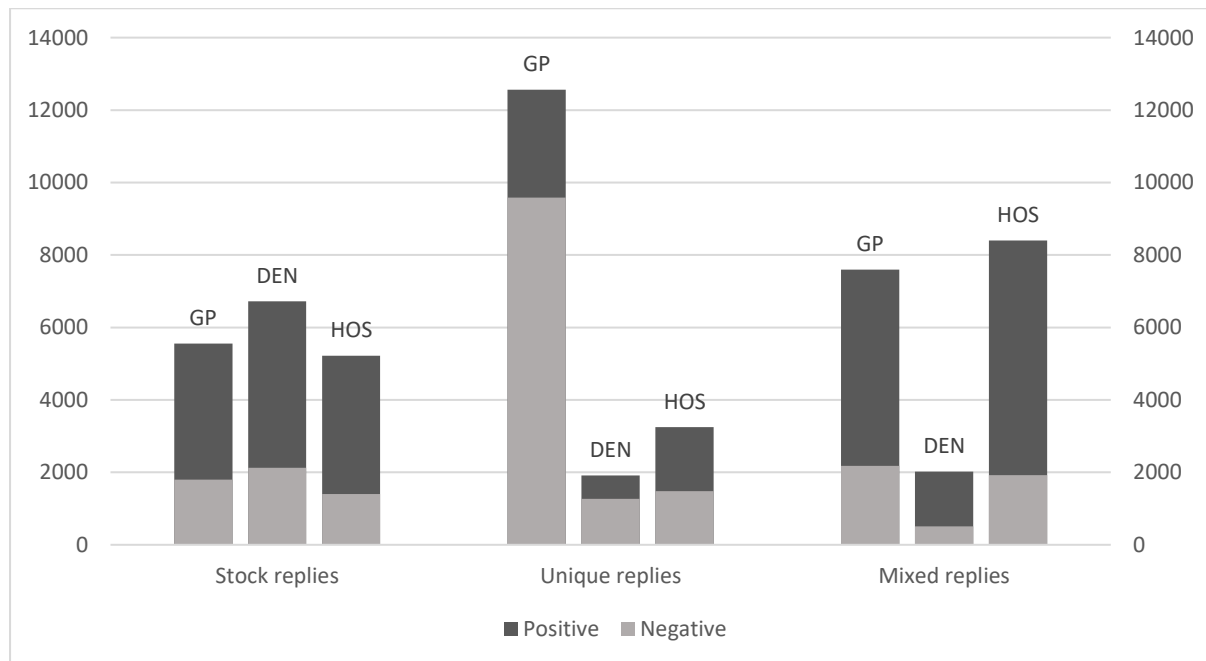
Figure 4.4 Reply types divided into three main service areas and proportion of negative to positive original comments

Figure 4.4 suggests that staff are fairly consistent across service areas in the extent to which their use of stock replies tends to favour positive feedback. A similar pattern is suggested with the results for mixed replies, where negative–positive proportions with a sizeable positive majority are consistent across service areas, despite notable differences in the number of mixed replies between service areas. The pattern is different for unique replies, where the high tendency to respond to negative comments is consistent across GP practices and Dentists, but Hospital staff in fact seem to use unique replies slightly more in response to positive than negative feedback.

However, these results do not take into account differences in the proportion of negative–positive comments in different service areas, and the fact that the rate at which staff respond to positive or negative comments may depend largely on the amounts of positive and negative comments available for them to respond to. How the proportion of responses to negative and positive comments by staff in each of the main service areas using different reply types compares to the proportion of negative–positive comments in those service areas is shown in Table 4.3 below.

Table 4.3 Comparing proportions of replies to negative and positive comments to negative–positive proportions of original comments

	Total (+ and – texts)	% positive	% positive comments	% negative	% negative comments
Stock					
GP practices	5,554	67.64%	52.58%	32.36%	47.42%
Dentists	6,722	68.36%	71.92%	31.64%	28.08%
Hospitals	5,218	73.13%	73.04%	26.87%	26.96%
Unique					
GP practices	12,561	23.68%	52.58%	76.32%	47.42%
Dentists	1,911	33.70%	71.92%	66.30%	28.08%
Hospitals	3,252	54.55%	73.04%	45.45%	26.96%
Mixed					
GP practices	7,596	71.30%	52.58%	28.70%	47.42%
Dentists	2,024	74.75%	71.92%	25.25%	28.08%

Hospitals	8,397	77.10%	73.04%	22.90%	26.96%

The rows highlighted in dark-grey in Table 4.3 represent cases where there are notable differences between how reply types are used in particular service areas to respond to positive and negative feedback and the rate at which positive and negative comments occur in those service areas. For example, Dentist staff only use unique replies to respond to positive comments 33.70% of the time even though positive comments occur 71.92% of the time in this service area.

This suggests that the evaluative position of comments has an influence on Dentist staff members' use of unique replies. In fact, the evaluative position of comments seems to influence the choice to use unique replies in all three service areas. GP practice staff use unique replies to respond to positive comments only 23.68% of the time, even though they occur 52.58% of the time in this service area; and although unique replies are used more often by Hospital staff to respond to positive feedback (54.55%), this is still much lower than the proportion of positive Hospital feedback (73.04%).

These results show that the fact that feedback is negative will have a strong influence on healthcare staff choosing to use unique replies, regardless of service area. This is less the case with the other reply types, where the choice of Hospital and Dentist staff to use stock or mixed replies does not seem to be particularly influenced by whether comments are positive or negative. For example, even though stock replies are used by Hospital staff to respond to positive comments 73% of the time, this represents the same proportion of positive Hospital comments, and would therefore be the same result if every Hospital comment had received a stock reply.

However, use of stock and mixed replies does seem to be influenced by the evaluative position of comments in the case of GP practice replies. Staff in this service area use stock replies to respond to positive feedback at a 15% greater rate than positive comments occur, and mixed replies to respond to positive feedback at an 18% greater rate. This suggests that GP practice staff are more reactive to whether comments are positive or negative when using all of the reply types, whereas Hospital and Dentist staff seem to only be particularly reactive when favouring unique replies to respond to negative feedback.

The reason for these findings might be explained by the greater tendency for Hospitals and Dentists to use replies to feedback based on reused text, which occurs approximately 80% of the time in both service areas (see Figure 4.1). The regular practice of using stock and modified stock replies means that staff in these service areas are less likely to engage with individual comments to the same degree as GP practice staff who produce a high number of individually written replies.

That the latter group are more in the habit of engaging with individual feedback may have an influence on how they use stock and mixed replies; that is, they may use them more when it is arguably appropriate to do so, such as when feedback is positive (see explanation in Section 4.3). With Hospitals and Dentists, this distinction of suitable usage is probably not made because of the automated nature of their frequently reusing text.

4.5 Conclusion

This chapter has highlighted patterns in how reply types are linked to the service area in which replies were produced and the evaluative position represented by original patient comments. Overall, the results show variation in reply type preferences between the service areas. Suggested explanations for these preferences highlight the different nature of different kinds of NHS service.

Whether patient feedback is positive or negative also appears to be a determining factor in which reply types staff use. The findings suggest that staff use of unique replies in all three service areas is particularly influenced by feedback being negative. This is also the case with GP practice staff using stock and mixed replies more to respond to positive feedback, though there is little evidence to suggest that Hospital and Dentist staff are influenced by the evaluative position of feedback when they produce these reply types.

The patterns that have emerged from linking reply types and the metadata considered in this chapter help to highlight different text production tendencies of healthcare staff. Such information may be useful for providing context to the language-based analysis in the three chapters that follow.

Chapter 5: Analysis of Stock Replies

5.1 Introduction

In this chapter and the following two, I will present analyses of each staff reply type, starting with stock replies in this chapter. Stock replies are staff replies that match at least one other reply by 95% or more (see Chapter 3 for details), meaning they will mostly represent texts used more than once to respond to different feedback. The reusability of stock replies suggests they will likely consist of standardised ways of responding to feedback, and therefore also the recurring use of similar language. In this way, stock replies provide an appropriate starting point for investigating the language of staff replies.

The stock replies dataset examined in this chapter is made up of 25,835 texts and 1,736,165 words, which comprises 20% of the staff replies corpus. Stock replies range from one-size-fits-some to one-size-fits-many, as suggested by the fact that 17% occur only twice, 69% five times or more and 45% 20 times or more. To illustrate the extent to which replies represent reusable stock text, the frequency of replies is provided with examples in this chapter. Stock replies also include many texts that are very short and may be based on naturally produced formulaic sequences. For this reason, only stock replies with 20 words or more (85% of the stock replies) are included in the analysis.

The advice to staff provided by NHS Choices is not to use stock replies (see Section 3.3 for a summary of recommendations). The rationale for this advice may be that stock replies are impersonal, and by their nature contradict the principle of patient-centred care (discussed in Section 1.5.1). That stock replies are frequently produced raises the question of why staff often defy the advice provided, while also suggesting the possibility that staff may have a good reason for producing such replies. Considering explanations for why staff produce stock replies will form part of the analysis presented in this chapter. The analysis will address the following two research questions:

RQ2.   How do linguistic choices position staff, patients and the relationship between them, and how does this relate to the concept of patient-centred care?

RQ3.   How does staff use of language reflect different discourses in terms of (a)

              register and (b) ways of viewing the world, and how do these relate to patient-

              centred care?

The structure of this chapter is as follows. Section 5.2 presents an analysis of the discourse

functions of the most frequent boilerplate chunks (word sequences) in the stock replies

dataset, and linguistic variation between chunks that serve the same discourse function.

Section 5.3 presents an analysis of these discourse functions at a text level, which includes

using a sample text to examine how they constitute a reply, identifying the sequence patterns

of discourse functions in 50 random sample texts and analysing linguistic variation between

several replies with identical sequences. Section 5.4 reports on the findings from a qualitative

analysis of sample stock replies, and Section 5.5 looks at replies, and the original feedback of

those replies, as part of an investigation into the extent to which replies match or mismatch

feedback. The chapter then concludes with Section 5.6 which reflects on findings that address

the research questions.

5.2 Discourse functions and language of repeated word sequences

The nature of stock replies as self-contained compositions intended for reuse to respond to

multiple patient comments means that they tend to be deliberately structured texts with staged

segments that serve particular discourse functions. The aim of this section is to identify and

describe those functions as a basis for providing an account of the discourse of stock replies.

A further aim is to investigate the language used to perform these functions, which will focus

on the relational aspects of staff language use.

The method used to classify discourse functions is that of identifying the most frequently

repeated word sequences in a subcorpus of stock replies that contains only single instances of

those stock replies. The boilerplate chunks tool in WordSmith 7 was used to identify the top

20 most frequently repeated word sequences in texts linked to positive comments from the

three main service areas (GP practices, Hospitals and Dentists), and also in texts linked to

negative comments. Positive and negative comments were determined by the responses to a

questionnaire question, linked to feedback, which asked how likely patients were to

recommend a service to friends and family. From a choice of options on a Likert scale, those

with the response 'likely' or 'extremely likely' were classified as positive, and those with the

response 'unlikely' or 'extremely unlikely' were classified as negative. Among the total 25,835 stock reply texts, 17,494 (68%) (for the top three service providers) were linked to feedback that provided one of these responses to this question; 70% of these were to the positive options, and 30% to the negative options.

The boilerplate chunks generated were those that occur in a range of 15 to 400 characters, which produced word sequences ranging from three to seven words in length. The reason for using boilerplate chunks instead of fixed-length clusters is because an initial test searching these found them to be problematic. In a corpus of texts intended for reuse, the language is highly formulaic and includes repeated long sequences which create interference when searching shorter fixed-length clusters. A test found that these would often represent different overlapped segments of the same few long clusters. To address the problem of overlapping, boilerplate chunks were identified, which represent sequences from the sentence boundary (see Section 3.7 for an explanation of these).

These word sequences (boilerplate chunks) were then used to identify different discourse functions. As the length of boilerplate chunks can vary, inferences about what function they represent can be easier to make with those that contain more words. Therefore, concordances of shorter chunks were reviewed to guide the classification of these. The discourse functions are displayed in Table 5.1 along with examples of word sequences used to identify them and the total number of word sequences identified (i.e. single instances of stock replies plus any copies of these) for each discourse function category; these are divided based on whether they were used to respond to positive or negative comments, and the relative percentage of positive to negative for each category is provided in brackets.

Table 5.1 Frequencies of boilerplate chunks

Discourse function	Typical chunks	Positive	Negative
Thanks	Thank you for your feedback/comments…	9,863 (78%)	2,731 (22%)
Value statements	The practice aims…	955 (83%)	200 (17%)
Offers/requests	We would like the opportunity to discuss…	3,077 (49%)	3,220 (51%)

Affective expressions	It is always nice/good to/a pleasure…	3,069 (96%)	126 (4%)
Apologies	I would like to apologise…	0	2,676 (100%)
Reported action	I/we will pass your/share your…	1,696 (89%)	220 (11%)
Explanations	We are currently…	180 (45%)	224 (55%)

Thanks and apologies

The minimum politeness requirement of staff when patients post comments is to acknowledge the comment. Stock replies are a way for staff to achieve this if they do not have time to respond more fully. That routinised politeness is the most frequent discourse function identified is to be expected. Added to this is the context of service provision, where politeness routines are strongly established norms.

Even when taking into account the fact that 70% of the replies looked at in this section are in response to positive feedback, the tendency to respond with thanks is greater when staff are replying to positive feedback (approximately 78% of replies with thanks are to positive comments, and 22% to negative). This suggests that there may be a tension between the larger goals of the NHS organisation, where feedback – good and bad – represents a resource for helping improve services and therefore all arguably merits thanks in equal measure, and the personal feelings of staff when they receive criticism.

Affective expressions

These also represent politeness, but more than the minimum expected routine that politeness norms demand. They represent relational work in the sense that staff expressing how patient feedback makes them feel addresses the possible face needs of patients. The majority of affective expressions occur in response to positive comments. This can be explained by the fact that many sequences categorised as apologies[5] also arguably function as affective expressions.

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[5] Uses of *sorry* do not necessarily denote apology, but the strong association between this word and the act of apologising means it is likely to be construed as such even if it is not intended this way.

Reported action

Reported action is another discourse function that represents relational work. However, whereas affective expression is relational work in the sense that it involves staff sharing their feelings in a way that shows they care, reported action is relational work because it is about conveying to patients that their providing feedback has outcomes and is therefore worth doing. In this way, it may help patients feel good about providing feedback. Based on the most frequent word sequences, reported action occurs notably more frequently in response to positive feedback. This can be explained by the fact that the kinds of reported action represented by the sequences identified in this analysis mostly refer to staff having passed on feedback to other parties, as occurs when the good news of positive feedback is being shared. Such reported action does not represent staff acting on feedback in a way that will have significant outcomes. Even with stock replies, a possible sequence to include might be the reporting of discussing complaints at staff meetings, but no evidence of this was found among the most frequent boilerplate chunks identified in this section.

There is a very small amount of evidence of reported action in response to negative comments when staff report on making improvements as a result of comments, a practice known as 'you said, we did'. The reason why this does not occur more often may be because reporting specific action in response to specific feedback is not possible with stock replies. However, this shows that a more general representation of 'you said, we did' is possible and has the benefit of helping patients feel that their feedback has consequences.

Offers/requests

The discourse function of offers or requests typically involves the offer or request for further contact. Its frequent occurrence in response to both positive and negative feedback suggests it represents a general politeness routine, such as to signal that staff are available to be of assistance beyond the end of the textual response to feedback. However, that it is a frequent function in stock replies could also suggest that the offer or request for offline contact conveys a preference for such interaction, which might explain why staff have not produced an individualised reply.

Explanations

The discourse function of offers or requests represents management practice, which also appears to be represented by explanations. This refers to when staff provide stock

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information, which may be regarding standard procedure or a general update. Repeated word sequences that represent explanations do not occur very frequently in the data, which can be attributed to the fact that for information to be useful it usually needs to be tailored and therefore is less likely to be found in stock replies.

Value statements

This discourse function also represents management practice; one that involves staff representing organisations by stating certain values. Value statements represent an influence of corporate discourse on the language of healthcare staff, and can be used by staff to reproduce a consistent organisational message. Value statements in the data also occur notably more often in response to positive than negative comments. A reason for this may be that they represent a promotional performance, a kind of boast, which staff might feel less inclined to make when responding to negative comments.

In order to consider whether, and to what extent, the above discourse functions represent distinct characteristics of stock replies to online patient feedback, I repeated the same process used to identify the most frequent boilerplate chunks in stock replies on another reply type, unique replies. Unique replies represent individualised responses (see Section 3.4), and a full analysis of these will be presented in the next chapter. The most frequent boilerplate chunks for unique replies fit the same categories identified for stock replies. The frequency of chunks in the different discourse function categories is displayed in Table 5.2 below, alongside the same for stock replies (previously presented in Table 5.1, and reproduced here for purposes of comparison).

Table 5.2 Comparison of stock and unique reply boilerplate chunk frequency[6]

Discourse function	Frequency of top boilerplate chunks in stock and unique replies			
	Stock positive	Unique positive	Stock negative	Unique negative
Thanks	9,863	2,336	2,731	2,198
Value statements	955	0	200	0
Offers/requests	3,077	84	3,220	968

[6] Stock replies comprise 20% of staff replies, and unique replies 19%. Therefore, this comparison of frequencies is based on datasets consisting of a similar number of texts.

Affective expressions	3,069	367	126	203
Apologies	0	75	2,676	2,735
Reported action	1,696	61	220	0
Explanations	180	71	224	860

Table 5.2 illustrates how formulaic sequences to express thanks, as represented by recurring boilerplate chunks in the data, occur at a similarly frequent rate in both stock and unique replies when staff respond to negative feedback. However, significantly more chunks are used to express thanks in stock replies than unique replies when staff are responding to positive feedback – over four times as many. The much lower tendency for staff to use formulaic thanks may be because they want to convey their gratitude in a more individualised way when producing unique replies to praise. The same explanation might be used for the results of the affective expressions category, where the number of boilerplate chunks is similarly low when both reply types are used to respond to negative feedback, but notably more infrequent in unique replies than stock replies when responding to positive feedback. With apologies, which occur almost entirely in response to negative feedback, the frequency of chunks is very similar between stock and unique, which suggests that apologies tend to be formulaic regardless of whether staff are producing individualised or generic responses.

The only discourse function category in which unique replies has notably more boilerplate chunks than stock replies is explanations: 860 compared to 224 when staff are responding to negative comments. Such sequences include *we are currently* and *we have recently*; for example, *We have recently increased the number of incoming phone lines and updated our switchboard*. That formulaic features indicating explanation occur more in unique replies, and in response to negative feedback, might be explained by the fact that a reason for replying individually to feedback could be to address patients' specific complaints. That staff reproduce the same linguistic features when providing explanations could be attributed to common complaint-handling strategies, such as describing an ongoing or recent activity as part of an explanation for how a service is being improved.

Perhaps the most striking result displayed in Table 5.2 is that for value statements. Although the frequencies for value statements are not as high as those for a number of other discourse

functions, evidence of this discourse function occurs only with the most frequent boilerplate chunks in stock replies, and not unique replies. This suggests they are a distinctive feature of this reply type. Frequent boilerplate chunks identified for value statements in stock replies include *Your feedback is*, *We value all comments from* and *We will continue to*, for example:

> **Your feedback is** vitally important to us and we hope to continue to deliver you with a high standard of care
>
> **We value all comments from** patients to help us review and improve our service
>
> **We will continue to** meet your health care needs and provide you with an excellent service

With value statements, the linguistic choices of staff appear to reflect an influence of factors outside the local interactional situation, specifically norms associated with the corporate world. This is suggested by use of the plural first-person pronoun *we* in the examples above. When used to parrot an organisational message, this becomes corporate-*we*, which can help synthetically personalise public service organisations like the NHS by representing them as if they were individuals with their own voice (Fairclough, 1993).

Other differences between stock and unique replies, suggested by the results in Table 5.2, are the notably higher occurrence of the discourse functions offers/requests and reported action in stock replies compared to unique, based on the most frequent boilerplate chunks in these two reply types. The higher reported action can be attributed to the fact that stock replies are limited to reporting general action, which is typically that of passing on feedback, whereas individualised replies have more options to describe a variety of specific outcomes of feedback. This means there is less call to reuse the same formulaic construction when staff produce unique replies.

With offers/requests, the difference between stock and unique is less pronounced when staff producing individualised replies are responding to negative feedback. In fact, after thanks and apologies, offers/requests is the next most frequent discourse function identified for unique replies. That this is primarily when responding to negative feedback suggests that, while an offer or request for further contact may be a formulaic politeness routine across both reply types, in unique replies it specifically serves a complaint-handling purpose.

The remainder of this section will focus on linguistic variation within the same discourse function categories in stock replies. The two categories examined are affective expressions and offers/requests. These have been selected because the high frequency of the most common boilerplate chunks in these categories suggests they are characteristic of stock replies, and because the language used provides enough variation to consider for analysis. The analysis will focus in particular on what variation reveals about different ways staff position themselves through their linguistic choices, and begins by looking at the language of boilerplate chunks in the affective expressions category. Boilerplate chunks for this category that occur in response to positive comments have been divided based on sentence-initial pronominal choice, and these are displayed below in Table 5.3.

Table 5.3 Boilerplate chunks from the category 'Affective expressions' (response to positive only)

Sentence-initial pronoun	Boilerplate chunks (number of unique texts containing this chunk/total number of texts containing this chunk)
Plural first-person (*we*)	We are pleased that (80/478)
	We are pleased to (50/182)
	We appreciate your (19/65)
	We're pleased to hear (14/50)
	We are delighted (9/69)
	We really do appreciate (9/26)
	We are very pleased that (8/24)
	We appreciate you taking (5/32)
Singular first-person (*I*)	I am very pleased (21/1,189)
	I am pleased to hear (6/25)
Dummy pronoun (*it*)	It is always a pleasure (27/244)
	It is much appreciated (18/45)
	It is always good (15/49)
	It is always nice (12/33)
	It is always good to (9/22)

Affective expressions in stock replies can be made using different sentence-initial pronouns that represent the identity of authors of replies in several ways. These include use of the

plural first-person pronoun *We* which represents staff as a group, singular first-person pronoun *I* which represents the writer as an individual and the dummy pronoun *It* which allows for the expression of a feeling or attitude without referencing the person or people who have experienced this. While use of the singular first-person occurs more frequently overall than plural, this is mostly based on a high number of duplicates of a limited number of texts (i.e. the single sequence *I am very pleased* occurring 1,189 times based on only 21 different texts). In terms of individual instances of stock replies (i.e. not counting duplicates), *we* is more common, as the figures and variety of uses displayed in Table 5.3 illustrate.

While use of the singular first-person pronoun is more individualising than use of the plural first-person pronoun, this does not necessarily mean it produces a more personalised effect. The effect of other language choices must be considered. For example, the strength of the emotion word used in an affective expression is likely to have a significant bearing on how much patients feel their positive feedback has been appreciated: the effusive *We are delighted* is probably likely to engage patients more than *I am pleased to hear*, irrespective of the pronoun used. Also, construal of the identity of the referent, when plural first-person *we* is used, is likely to affect the extent to which patients experience staff language as personalised. When used as part of a seemingly parroted corporate message ('we value all feedback'), it might be more likely to produce an impersonal effect, compared to the *We are delighted* example where the strong emotion word suggests it is the group of individuals who work at the practice who are represented by *we*. However, plural first-person pronouns are ambiguous, and the unclear distinction between organisational and personal *we* may mean that its effect on patients depends on their individual experience of such language use.

The most frequent word sequences from stock replies that belong to the affective expressions category also include variation representing a choice between the use of a person/people-indicating pronoun or a dummy pronoun. The use of a dummy pronoun in affective expressions is impersonal in the sense that it involves omitting the experiencer of the feeling being expressed, which creates the effect of staff appreciation as an idea rather than something they really feel.

However, consideration of the relational implications of affective expressions needs to take into account how words are used in combination. For example, a construction like *It is always a pleasure*, which semantically represents the idea of ongoing enjoyment, is emphatic

in a way that might be associated with mannered formal politeness. While such language use might seem overly performed and impersonal in some contexts, such as face-to-face situations, in stock replies it might well be evaluated as favourably human in contrast to the kind of formulaic, mechanical use of language that can occur.

The discourse function offers/requests is considered next. Boilerplate chunks that occur in response to negative feedback for this category have been divided based on sentence structure and are displayed below in Table 5.4.

Table 5.4 Boilerplate chunks from the category 'Offers/requests' (response to negative only)

Sentence structure	Boilerplate chunks (number of unique texts containing this chunk/total number of texts containing this chunk)
Conditional	If you would like (209/964)
	If you wish to discuss (22/87)
	If you contact our (3/8)
Imperative	Please contact the (118/445)
	Please can I ask (31/706)
	Please feel free to (22/84)
	Please could you contact (10/36)
	Would you please (4/17)
First person	I would very much (10/110)
	We would like the opportunity to discuss (7/36)
	I look forward to hearing from (6/16)

Offers or requests, typically for further contact between staff and patients, can take several forms based on sentence structure. The most common form, in terms of the number of distinct stock replies it occurs in, is that which starts with conditional *if*, whereby the proposition of further contact is formulated as an open offer. In this form, offers or requests could be said to function as formulaic politeness. In other forms, this discourse function represents requests that require patients to act in a way (i.e. making direct contact) desired by the staff member. Achieving this requires a persuasive use of language, and this is illustrated in the sentence structure categories in Table 5.4 by two strategies used by staff.

One strategy is to use imperatives – sentences that start with *Please* that represent an instruction for patients to act – and although there are subsequent hedges (*can I ask*, *could you*), use of imperatives still represents a direct, business-like call for cooperation. The second strategy involves staff using first-person pronouns to represent further contact as a desire or expectation (e.g. *We would like the opportunity to discuss*). This takes the form of an indirect request which, by representing further contact as a desire of staff, implies that patients would be doing staff a favour by acting on this request.

These two strategies seem to index different staff–patient relationships; ones that are linked to different healthcare discourses. The first strategy implies a relationship of staff authority and patient compliance, which links to a traditional paternalistic view of healthcare whereby patients are expected to comply with the instructions of staff. The second strategy implies a more egalitarian staff–patient relationship, and perhaps even one where staff are in a subordinate customer service role, and this might be said to be linked to a consumerist view of healthcare. The effectiveness of the different strategies used to induce patients to make contact with staff will likely depend on their perspective of the role of healthcare staff, together with the remaining content of the staff reply.

To sum up, the findings from the above analysis highlight how stock replies can consist of two main purposes: to carry out relational work and to perform management activities. The discourse functions identified may serve one or both of these purposes. However, they can also potentially come into conflict, such as when an offer or request for further contact is used to initiate offline communication rather than staff using the online space to engage with the patient and carry out relationship repair work when this might be needed.

One way that the conflict between the different purposes of stock replies might be averted is through the use of language strategies, the potential for which has been highlighted by a consideration of language variation. However, regardless of the linguistic choices staff make, stock replies fundamentally have an impersonal nature. This is particularly apparent when the conditions of production and reception are taken into account. Whatever kind of language staff use, on a platform such as NHS Choices where comments and replies for the same practice are displayed on the same webpage, commenters who receive stock replies will be able to scroll through and see other feedback that has received the same reply. Therefore, they will know that they have received a copied and pasted response no matter what

personalising strategies might have been employed by staff.

5.3 Discourse functions and language at a text level

The previous section provided an account of stock replies by looking at the discourse functions of repeated word sequences across a corpus. This section looks at discourse functions in terms of how they occur in combination within a text. This will take into account any positional tendencies of different discourse functions in a text, as well as any patterns of discourse functions occurring in particular combinations. This section also considers staff language choices and how these relate to discourse functions at a text level. In particular, it will focus on variation in the relational implications of language between texts that share the same composition of discourse functions.

How discourse functions combine at a text level is illustrated in Table 5.5, where a sample stock reply is displayed in segments identified based on the different discourse functions they serve.

Table 5.5 Stock reply representing discourse functions at a text level

Discourse function	Stock reply divided into segments
Thanks	Thank you for your comments.
Apology	We are sorry that your experience of our service recently has not been a good one.
Explanation (or any info provision)	Like many practices we are currently experiencing a high demand for appointments,
Concession	we also recognise that there are areas that need improvement
Value statement	and we do actively listen to our patients' concerns
Reported action	and make changes to our systems, processes and procedures as required. Your comments include a few things we can learn from and include in our improvement measures.
Offer or request	If you would like to discuss your comments further, please call the surgery and ask to speak to the practice manager.

Looking at discourse functions at a text level can help provide a clearer picture of how they function when used in combination. For example, the routine politeness elements 'thanks' and 'apology' function as openings to the text, and the 'offer or request' element functions as a closing, in a way that also works as a politeness routine. In this regard, they serve a text organisational role. In between these, 'explanation', 'concession', 'value statement' and 'reported action' all combine as part of a rhetorical function. The argument strategy being employed with this combination of elements is as follows. The cause of the patient's negative experience is attributed to factors beyond staff control ('explanation'), which could be seen as an appeal to absolve staff of some blame. This is followed by an admission of some responsibility ('concession'), which is immediately mitigated by positive self-representation ('value statement'). Finally, a solution to the problem of the patient's negative experience is presented in the form of stating that the comment will be used to make improvements ('reported action').

Considering these in combination at a text level highlights the extent to which an argument strategy may constitute a staff response to patient feedback, in a way that is not observable when looking at individual discourse functions out of context. However, this sample was deliberately selected to illustrate a variety of discourse functions in a single text. In practice, stock replies to online patient comments on NHS Choices are not usually as complex as is suggested by this example.

A more accurate picture of how stock replies are structured in terms of discourse functions is provided below in Table 5.6. Here, 50 different stock replies have been randomly selected and coded using the discourse function categories identified in the previous section. The discourse functions that occur in each of the sample texts are indicated in the table, as is the order in which they occur (indicated in the 'Sequence' column). The table has been split between those that include apologies and those that do not for ease of identifying structural patterns.

Table 5.6 Discourse function coding of random sample stock replies

	Includes apologies							
	Thanks (T)	Apologies (S)	Val. stat. (V)	Explan. (E)	Off./req. (O)	Rep. action (A)	Affect. (F)	Sequence
Txt 1		X			X			SO
Txt 2		X			X			SO
Txt 3		X		X				SE
Txt 4		X		X	X			SEO
Txt 5		X			X	X		SAO
Txt 6	X	X			X			TSO
Txt 7	X	X			X			TSO
Txt 8		X	X		X			VSO
Txt 9	X	X		X	X			TSEO
Txt 10	X	X			X		X	TFSO
Txt 11	X	X	X	X	X			TSEVO
Txt 12	X	X	X		X	X		TSVAO
Txt 13		X		X	X	X		SEOAS
Txt 14		X			X	X		SAOAS

	Thanks (T)	Apologies (S)	Val. stat. (V)	Explan. (E)	Off./req. (O)	Rep. action (A)	Affect. (F)	Sequence
Txt 15		X	X		X	X		SVAOA
Txt 16	X	X	X	X	X	X		TSAOVE
Txt 17	X	X		X	X	X	X	TSEAFOS
Does not include apologies								
	Thanks (T)	Apologies (S)	Val. stat. (V)	Explan. (E)	Off./req. (O)	Rep. action (A)	Affect. (F)	Sequence
Txt 18	X							T
Txt 19	X							T
Txt 20	X							T
Txt 21	X							T
Txt 22					X			O
Txt 23	X						X	TF
Txt 24	X						X	TF
Txt 25	X						X	TF
Txt 26	X						X	TF
Txt 27	X						X	TF
Txt 28	X						X	TF

Txt 29	X					X		TA
Txt 30	X					X		TA
Txt 31			X			X		VA
Txt 32	X		X					TV
Txt 33	X					X	X	TFA
Txt 34	X					X	X	TFA
Txt 35	X					X	X	TFA
Txt 36	X					X	X	TFA
Txt 37	X					X	X	FTA
Txt 38	X		X		X			TVO
Txt 39	X		X		X			TVO
Txt 40	X		X	X				TVE
Txt 41	X				X		X	TFO
Txt 42	X		X				X	TFV
Txt 43	X					X	X	TAF
Txt 44	X		X			X	X	TFAV

Txt 45	X		X				X	TVFV
Txt 46			X	X			X	FEVE
Txt 47	X		X			X	X	TFVFA
Txt 48	X		X			X	X	TFVAF
Txt 49	X		X		X	X	X	TVAFO
Txt 50	X			X	X	X	X	TFAFOEOT
Total	38	17	17	10	22	21	23	

Coding the sample texts reveals that more often than not, stock replies tend to be fairly simple texts, with over two-thirds of the sample (68%) consisting of between one and three discourse functions. With only two texts in the sample being divisible into as many or more discourse function segments as the example considered above, the finding that discourse functions can be orchestrated to create a particular rhetorical effect does not seem likely to be typical of the majority of stock replies. In this sample, there are 34 different types of pattern with TF, a simple text consisting of 'thanks' followed by 'affective expression' occurring six times and therefore representing the most common type in the sample.

A review of the coded sequences of discourse functions presented in Table 5.6 helps corroborate the finding from the analysis of the example stock reply displayed in Table 5.5 that 'thanks' and 'apologies' tend to occur as openings at the start of replies, and 'offers or requests' as closings at the end. An additional finding from this coded sample of texts is that certain discourse functions often occur together: in particular, 'thanks', 'affective expressions' and 'reported action'. In 17 of the 23 texts that include 'affective expressions', this occurs immediately after 'thanks', and in 12 of the 14 non-apology texts that include 'reported action', this immediately follows either 'thanks' or 'affective expressions'. The link between these discourse functions is that staff often represent feelings of appreciation immediately after expressing gratitude in response to positive feedback, and that 'reported

action' primarily refers to sharing positive feedback with other staff, which also functions as a representation of appreciation.

Another pattern revealed by the coded discourse function sequences of the sample texts is the tendency for value statements to occur anywhere in a sequence: at the start, middle or end, and in positions immediately following every other type of discourse function on at least one occasion in the sample. Whereas all the other discourse functions often follow a pattern, either positionally or by tending to occur with particular other discourse functions (e.g. 'explanations' immediately follows 'apologies' in six out of the seven times they occur in the same text), value statements do not seem in any way to be structurally constrained. This positional flexibility of value statements suggests their nature as added extras in stock replies, and reflect the fact that their presence relates to a wider discourse function – to represent an organisational identity – rather than a more local interactional function.

A difference to note between coded sequences of texts that include 'apologies' and those that do not is that over half of the 'apologies' texts consist of four or more discourse function elements, which is the case for only about a fifth of texts without 'apologies'. This suggests that replies that acknowledge patients' negative experience are more likely to require a higher number of functions, which might be explained by the fact that addressing complaints involves more work than reflecting praise, even in stock replies. The difference between the apology and non-apology texts also corroborates some of the findings from comparing responses to negative and positive comments in Section 5.2, even though a non-apology text does not necessarily mean that it has been used in response to positive feedback. Only two of the apology texts include 'affective expressions' compared to 21 non-apology texts, while 16 (all but one) include 'offers or requests' compared with six non-apology texts.

By revealing similar discourse function tendencies between negative and positive to those found in the previous section, the findings from this qualitative analysis of random samples suggest that identifying discourse functions based on the most frequent word sequences has produced results that are fairly representative of stock replies. One notable exception is 'reported action', which similarly occurs 41% and 42% of the time in apology and non-apology texts, respectively, while it is almost only ever used in response to positive comments according to the most frequent word sequence (i.e. boilerplate chunk) findings. The reason for this is the tendency for the same kind of action to be reported in response to

positive comments (i.e. passing on positive feedback to staff), which, when represented by the same wording, has caused it to be flagged up in an approach based on frequency. Overall, though, the fact that the same discourse function categories identified in Section 5.2 can be applied to the qualitative sample texts suggests they provide a reliable account of the discourse of stock replies.

The remainder of this section will look at the language of stock replies with respect to how discourse functions occur at a text level. Stock reply examples are displayed in segments to represent the constitution of texts in terms of discourse function; these are indicated by new lines that start with the same letter codes used in Table 5.6.

The analysis that follows will consider variation between the language of texts that share the same functions and structures. This focus on variation at a text level controls for influences on variation that are not controlled for when looking at discourse functions in isolation, such as potential influences on language based on other language use in the text. For example, a reason for a writer using a particular word or phrasing may be to avoid repetition of its use elsewhere in the text. By looking at texts that are functionally and structurally identical, any variation identified can be said to represent viable language use options for staff.

This is particularly pertinent when considering the relational implications of language use, where different options may vary in terms of personalisation and therefore be more or less preferable. Any different language choices of staff that occur between texts that are functionally and structurally identical may also reflect the influence of wider discourses of the language of stock replies.

Linguistic variation at a text level will be considered using the following four texts taken from the random sample of 50 stock replies. Each text shares the same discourse functions ([T] = Thanks; [F] = Affective expressions; [A] = Reported action), and in the same order:

1. [T] Thank you for your feedback.
    [F] I am so pleased that you had a positive experience
    [A] and I'll be sure to share your comments with the team.

2. [T] Many thanks for your feedback about the care and treatment you received whilst attending the emergency dental service at [NAME][7] in [PLACE].
[F] We appreciate you taking the time to tell us about your positive experience
[A] and will ensure that the staff are made aware of your kind comments.

3. [T] Thank you for your comments.
[F] We are delighted for had a positive experience of the service
[A] and will pass your remarks on to our staff.

4. [T] Thank you for your comment,
[F] it is always a pleasure to receive positive feedback about our services and staff.
[A] Please be assured that we will share this with the staff at [NAME].

The routinised nature of 'thanks' in stock replies to patient feedback means that it tends to be very formulaic, hence the almost identical language used for this discourse function across three of the four texts. Text 2 differs in that it provides information about the object of the thanks – not just saying *your feedback* but also specifying what the patient's feedback is about (i.e. *care and treatment* from a named service at a named practice). Together with somewhat informal *Many thanks*, this specification might be an attempt to personalise the reply but seems to produce an impersonal, official on-the-record effect.

The second discourse function in the sequence of the above represented texts is 'affective expressions'. This entails more variation than 'thanks', starting with Text 1 where use of a singular first-person pronoun and a conversational intensifier with *so pleased* makes this the most personalised of the affective expressions in the four texts. In Texts 2 and 3, the use of plural first-person pronouns, where the feelings being expressed are attributable to a group rather than an individual, makes these affective expressions less personal than that of Text 1. Text 3 seems likely to be more effective at engaging the patient than Text 2 because of its use of a stronger emotion word, *delighted*, compared to *appreciate*, which expresses greater enthusiasm for the patient's feedback, although this effect is slightly undermined by the

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[7] All named places, people and NHS practices in the data have been anonymised as [PLACE]/[NAME].

preceding typo (*for* where it should be 'you'). The language of the 'affective expression' in the final text is arguably the most impersonal of the four because of its use of a dummy pronoun to express a general feeling of appreciation without this being attributed to anyone. This produces a detached effect that is compounded by the corporate management phrasing of *our services and staff*.

Variation between the texts continues with the final discourse function in the sequence, 'reported action'. With the conversational effect produced by the combination of use of a singular first-person pronoun, a contraction and the informal phrase *be sure to*, Text 1 continues to seem the most personalised. The ellipsis referencing a plural first-person pronoun in the preceding clause, together with the corporate word *ensure*, make Text 2 less conversational. However, the inclusion of the adjective *kind* when representing the patient's *comments* conveys an appreciation that is more likely to engage the patient than the perfunctory reporting of action in Text 3: [we] *will pass your remarks on to our staff*.

Of the four texts, Text 4 seems the most impersonal with its use of language to report action. The instructional effect of use of an imperative (*be assured*) to tell the patient how they should feel has a business-like quality that implies the patient's feedback is being processed as a task. However, while such a language style may be experienced as impersonal by some patients, others may evaluate it positively for its associations with confidence and efficiency.

When comparing the language of the discourse functions in the four texts, Text 1 appears to be the most personalised and Text 4 the most impersonal. This judgement is primarily based on the fact that Text 1 includes conversational features that are informal and more likely to express relational closeness, while Text 4 includes a dummy pronoun and imperative in a way that conveys distance. However, when considering the relational effects of the language of each text as a whole, Text 2 is arguably the most impersonal. This can be attributed to the combined effect of the language of each discourse function: the deliberate on-the-record style of the 'thanks'; the muted, mechanical 'affective expression'; and the official wording of *staff are made aware of* in the final 'reported action' stage, a wording that seems to suggest staff will be informed about a serious matter rather than positive feedback. When taken as a whole, the language used in this text indexes a bureaucratic discourse, as suggested by the careful, official style associated with the management and legal aspects of such language use.

Looking at the language of discourse functions using a random sample of texts highlights some atypical examples of stock replies, such as the one below. Here, the value statement does not function as an added extra but instead appears as a defensive rebuff to a negative comment:

> [V] [NAME] take complaints against the quality of its services very seriously.
> [A] The points made in this review are currently being thoroughly investigated.

With no conventionalised opener that would help construct this as a self-contained text, such as routine politeness, the effect is to make the opening value statement seem like a conversational turn. The defensiveness of this opening is emphasised by the ominous wording of the subsequent reported action, *thoroughly investigated*, which creates an implicature of warning. This example demonstrates how a discourse function analysed as a decontextualised element (as is done in Section 5.2) might only be telling part of a story that is more fully revealed when the same discourse function is viewed at a text level.

This section has helped to provide more of an account of stock replies in terms of their composition at a text level. A main finding is the tendency for stock replies to often be simple structures, which suggests they are more likely to represent the sum of their parts (i.e. the individual discourse functions considered in Section 5.2) rather than something more, such as the argument strategy identified in the example text considered at the start of this section in Table 5.5. This section has also illustrated the special case of value statements and how these can occur in any position in stock replies. This reflects their status as added extras representing a wider discourse rather than the discourse that functions at an interactional level, even though there are exceptions to this rule. Finally, the consideration of linguistic variation in this section, between texts that constitute identical discourse function composites, has revealed the different choices available to staff to make stock replies more personalised while also highlighting the influence of wider discourses that discourage this.

5.4 Synthetic personalisation and synthetic impersonalisation

So far in this chapter, the focus has been on the discourse function of stock replies and language relative to these functions. This has involved looking at typicality based on frequency or emergent patterns, as well as approaching language from a discourse functional

perspective. This next section approaches the data from a purely language perspective with a focus on the interpersonal effects of language, specifically with regards to the theme of synthetic personalisation.

To this end, a further random sample of texts have been selected and reviewed and a qualitative analysis carried out. The purpose of this approach is to consider how language can be used in stock replies, based on evidence of how it is used, but without being constrained by the criteria of frequency or considering the way language serves particular discourse functions. This allows for a freer consideration of how staff use language for relational work, which is not necessarily clearly delineated in terms of the specific discourse functions identified.

The following analysis considers the phenomenon known as synthetic personalisation (see Section 1.5.2). This refers to when particular linguistic techniques have been used to create a personalised effect, such as when second-person *you* is used to address a large audience as though an individual were being addressed. Such attempts to construct personalisation may not always be effective; for example, when use of the personal pronoun *we* is identifiable with corporate value statements (see Section 5.2), which may be negatively evaluated and experienced as impersonal by patients. If such synthetic personalisation fails to achieve its intended personalised effect, it arguably represents synthetic impersonalisation.

This section will include some evaluation of the likely positive or negative effects of staff language use choices. For the analysis, 50 stock reply texts were chosen at random, and then reduced to 28 texts after ruling out replies found to be similar to other replies in the sample. The replies constituting the final sample were then analysed, with a focus on findings that illustrate the variety of ways that stock replies represent personalised and impersonal language use.

The formulaic quality of many sample stock replies can make them seem impersonal, although the line representing a concession in the sample text considered at the start of the previous section (Table 5.5) suggests a certain amount of fallibility: *we ... recognise that there are areas that need improvement.* However, the vagueness of the accepted shortcoming (*there are areas*) makes this seem like a hollow concession, particularly in contrast to the forthright acceptance of staff limitations represented in another stock reply:

for whatever reason (whether it be insufficient resources, or simply, at times, our own human frailties) we can't manage to satisfy everybody all of the time (4 texts)

This occurs in a stock reply that is reused only four times. When staff are expressing the potential for fallibility, more typical is the tendency for this to be subtly implied. For example, in a stock response used 177 times staff note how positive comments help them *identify where we're getting things right*, with the implication being that they can sometimes get *things* wrong. Words like *areas* and *things* are therefore suitably generalisable to be used to refer to a variety of different kinds of complaints.

When staff admit they have limitations, even if this is expressed indirectly, it makes them more relatable and seem more human, especially when compared to the undoubting confidence suggested by the corporate-like value statements which are common in stock replies, as the following examples show:

It is the ethos of the practice to welcome constructive feedback that will enable us to strive for continuous improvement (23 texts)

We take all feedback very seriously and we constantly look to improve our services (51 texts)

The first sentence consists of several features that seem to produce a detached and impersonal effect. These include the fact it is a passive sentence, and contains vague wording like *ethos* and the circumlocutory *will enable us to strive for continuous improvement*. Both examples not only represent improvement but also the idea that this should always be ongoing, which suggests a corporate style. This style can be associated with promotional language found to be evident in the sample; for example, when a reply describes a practice's aim as *[to] ensure [NAME] remains a leader in patient care and outcomes* (19 texts). Such use of language does not even seem to be addressing patients, but rather an imagined audience of big business actors like investors and shareholders, which reflects the influence of marketised discourse on the language of staff replies.

The value statements identified in stock replies represent evidence of promotional discourse, similar to that identified in research on universities' job adverts for lecturers which was

observed as having elements of marketing language intended to make the university seem prestigious (Fairclough, 1993). For example, the phrase *we strive to provide the best possible service* appears in 23 texts, and *we aim to provide our patients with the best care and treatment and this experience reflects our mission, 'Everybody matters, everything counts, everyone's responsible'* appears in three texts.

Statements that express that staff care about hearing from patients – for example, *We do actively listen to our patients' concerns* (25 texts) – seem to sometimes be undermined by the linguistic choices of respondents to feedback; for example, *we have only recently been given the administration rights to respond to your comment* (seven texts). While this forms part of an apology for the delay to responding and therefore conveys concern for the patient, the wording *administration rights* foregrounds the sense in which replying to feedback is a work task rather than part of a genuine desire to engage with patients. More directly opposed to expressions of valuing feedback are stock replies that refuse to engage with patients:

> We do not respond to anonymous feedback left on this website. The practice has a
> robust suggestions, comments and complaints procedure (4 texts)

This reply represents a rejection of online feedback as a valid means by which patients can convey their healthcare experiences, therefore suggesting that value statements may come with certain caveats; that is, accounts of patient experience only matter when these have been provided via the correct channels.

Sometimes, rather than abruptly reject online comments as an acceptable means for providing feedback, staff politely discourage them. By not being more accommodating of patients' choice about how to provide feedback, this represents a disregarding of the NHS principle of putting patients at the centre of care, as is the case with the following example:

> contacting the Practice Manager to discuss the situation is a far better option, as then
> improvements can be made and proper apologies offered (10 texts)

The wording *proper apologies* implies direct communication is more valid than providing feedback online, and while offering apologies may represent a relationship-repairing function, the suggestion that patients have acted inappropriately by commenting online runs

the risk of antagonising patients. This could especially be the experience of patients who are more comfortable making comments via a website than communicating with staff directly. In other excerpts from the sample, staff sensitivity to this kind of personal preference of patients is sometimes represented in the language they use:

> if you feel you could come forward (10 texts)

> while we understand that this can be difficult we welcome feedback in person (5 texts)

However, such responses could be viewed cynically as the responder wanting to discourage public airing of negative comments about an NHS service as part of an effort to protect the 'brand' of the practice they represent.

The preceding analysis suggests the greater tendency for personalisation to be represented as a principle than to be put into practice based on how language is used in stock replies. To some extent, this might be attributed to corporate values influencing staff to reproduce the same fixed positive promotional message in response to patients' online feedback. An effect of this is that staff replies do not function as turns in a conversational exchange, but appear instead as short marketised bulletins for promoting healthcare providers in a way that suggests they are commercial enterprises, as illustrated in the following example:

> [NAME] team is committed to a positive patient experience. We take it very seriously when this is not the case. Any complaints or suggestions for improvements are ALWAYS welcome. We are working in a highly pressurised environment but still the commitment and efforts from staff are always 100%. It is important for the staff to know when things are working well; sadly this is less likely when we are more likely to hear when things are going wrong. We are pleased your experience was positive and thank you for your feedback. (24 texts)

Features of corporate-like promotional language are evident throughout this text. These include the repeated use of *always* to convey the notion of consistent service quality (including once when the word is capitalised for emphasis); representing a group as a single identity of consciousness which allows for the claiming of collective beliefs and attitudes (*We*

take it very seriously); and nominalisations (*positive patient experience*) where verbs might have been used to represent the process of making patients happy or well. A particularly striking feature of this example is the dominance of self-reference (*[NAME] team*, *we*, *staff*) which contrasts with the perfunctory address of the patient in the last sentence. This produces a reply that is impersonal, where staff performance is of primary concern (the *team is committed*, *We are working in*, *It is important for the staff*) and the addressed patient seems to occur as an afterthought.

Evidence of marketised discourse is also present in the Table 5.5 example in the words *improvement measures* (in the 'reported action' segment), which conveys an ambiguous concept relating to organisational targets. In stock replies, such impersonal, vague language does not always stand out like this. For example, other language in the Table 5.5 example – *your experience of our service* (in the 'apology' segment) – could go unremarked upon as a reasonable way to describe the contents of patient feedback. However, the sample reviewed in this section reveals a more personalised way to represent the idea of patient experience; that is, by using the wording *looked after*, as in *It's good to hear you were so well looked after* (six texts). Here, a verbal process is used to represent patient experience in relational terms which, relative to abstract representations, foregrounds healthcare as something involving staff caring for patients.

Another notable feature of stock replies is the reporting of action, which was identified in Section 5.2 as one of the characteristic discourse functions of this reply type. The idea of staff acting on feedback is an important one, as illustrated by the widely used NHS slogan: 'you said, we did' (Costello and Charlesworth, 2017). In the Table 5.5 example, acting on feedback is represented as a point of principle by the abstract, non-committal words *make changes ... as required* (in the 'reported action' segment). This generic principle-based depiction of possible action is also evident in the sample under consideration here:

> Your comments have been noted and will be reviewed to identify opportunities for improvement and any actions that may be necessary (79 texts)

The passive agent deletions represented in this example omit the identity of who will be reviewing comments, identifying improvement opportunities and taking action, as well as

who has *noted* the comments, which all contributes to a sense of vagueness around whether anything will actually be done about the feedback.

Reporting action in response to feedback is a way that staff can show they have engaged with what patients are saying in their comments. Though stock replies limit the extent to which staff can specify actions, which is perhaps what leads to vague representations such as *new procedures are being initiated* (12 texts), general actions can be reported without having to be vague, as in the example *we are working towards a more efficient bookings system* (five texts). That said, reporting specific actions does not therefore mean that this will produce a personalising effect, as shown by the following example:

> We are currently re-training our reception team in order to provide a more caring and effective service (5 texts)

The representation of reception staff here suggests that they are service parts to be fixed and arguably obscures the sense in which they are human individuals. It does this by treating *caring* as a retrainable skill, but it is essentially a human emotion with a set of linked behaviours associated with moral qualities like kindness. In addition, being caring and being effective, while separate, are also represented as linked. Though the word *and* typically functions as a coordinating conjunction that joins words, phrases and clauses together, in this instance it can be interpreted as a sub-ordinating conjunction. This means 'in order to provide a more caring and effective service' can convey the meaning 'in order to provide a more caring and therefore effective service'. The wording of this example also suggests that the intention is not to train staff to care but to deliver a (more) caring service. This fits with the notion of synthetic personalisation, where the object is not necessarily to encourage real feelings of caring but to create an effect of such that will hopefully be indistinguishable from the reality. Such behaviour represents emotional labour, a concept that refers to managing and performing emotions and expressions to fulfil the requirements of a job.

The identification of discourse functions in Section 5.2 highlighted the function reported action, which typically entails staff reporting that they have conveyed or will convey feedback to third parties, as in *I will pass on your comments to the team* (71 texts). This represents a personalised act in that it proposes to single out staff to tell them about a specific individual's feedback. In this way, a personalised reply is not necessary to convey the idea of

a personalised action, which makes such language use effective for conveying caring in stock replies. The representation of conveyed feedback is a recurring practice across stock replies, as was found by reviewing 100 random concordances of the word *pass* which revealed it as referring to passing on feedback in all instances. The word *pass* was found to occur in 7.28% of all stock replies, suggesting a notable occurrence of this type of reported action in stock replies.[8]

Sharing feedback with other staff is a personalised action that can be further personalised in terms of style by using affective language and specific references. This is shown with the following examples from the stock replies sample:

> We have passed your kind sentiments to staff in our Haematology Department (91 texts)

> we will pass on your kind comments to the team (19 texts)

> It is with great pleasure that I have passed these on to the staff involved (4 texts)

The main focus in this section has been on the relational aspects of personalisation with respect to the language use of stock replies. The findings suggest that the best way for staff to achieve personalisation in stock replies is through the functional use of language, such as with promises to pass on feedback. This is arguably preferable to staff creating the appearance of stock replies being personalised, especially by using pronouns and engaging in politeness routines. The use of mission or value statements, characteristic of promotional discourse, will potentially be experienced as generic and repetitive by patients, and more so by those who regularly engage with NHS Choices and read the posted comments and replies. In addition to the linguistic choices of staff, personalisation may also be influenced by how staff use stock replies, an issue that will be considered in the next section.

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[8] Other words used for the same purpose, such as *share(d)* and *passed*, suggest a higher frequency of the reported action is likely, but the different uses of these words in the corpus prevent them from being used in the same way as *pass* to quantify this function in stock replies.

5.5 Matching and mismatching: comparing comments and stock replies

Much of the focus in this chapter so far has been on the functional and relational aspects of language at a text level. However, staff replies to patient comments posted online do not occur in isolation: they are part of a two-turn dialogic exchange and therefore merit consideration at an interactional level. To this end, this section investigates the relationship between staff replies and the original comments to which they respond. Specifically, it explores the compatibility of replies and comments, an issue that is especially relevant to stock replies where single texts produced to respond to multiple comments are at greater risk of mismatching than individually written replies.

This risk is demonstrated by a striking example from the NHS comments and replies corpus, where the stock text clearly mismatches the majority of the comments that it is used in response to. This is due to the specific information included in the reply, as the following excerpt illustrates:

> I have taken on board your comments regarding our receptionists and will be using this in order to provide feedback to reiterate the importance of providing excellent customer service to all of our patients (26 texts)

In only eight of the comments do patients refer to the reception or receptionists, meaning that this reply mismatches the other 18.

The complete mismatch between this stock reply and comments may have produced a negative or comedic effect on patients when they read the reply, but either way it suggests a lack of care that is arguably contrary to the purpose of healthcare. The potential for mismatches to occur when staff use stock replies puts at risk any relational work intended by staff replying to comments in the first place. For this reason, the issue of compatibility between stock replies and patient comments will be investigated further using a systematic approach.

To identify instances of potential mismatch, two evaluation words, 'positive' and 'negative', and two emotion words, 'happy' and 'unhappy', were identified in the top 250 most frequent words of a subcorpus of stock replies. The corpus processing website CQPweb was then used

to identify all original comments to stock replies containing these words where patients had also provided a response to the linked questionnaire question about whether they would recommend the practice or hospital to friends and family. The identified replies and comments were then filtered to leave only mismatching pairs where the score provided in response to the questionnaire question mismatched the evaluation or emotion word used; for example, stock replies with the word 'unhappy' where the original commenter provided a score of 4 or 5, indicating that they were 'likely' or 'extremely likely' to recommend the practice or hospital. Finally, the mismatched pairs were filtered to leave only stock replies where the identified evaluation or emotion words serve the function of recapping (e.g. excluding the use of 'happy' where it occurs with negation or to represent the feelings of staff rather than reflect those of the patient).

The results of this pairing and filtering process were that the number of identified mismatches for three of the words, 'happy', 'negative' and 'positive', was negligible (e.g. only two mismatches for 'negative'). Therefore, the following close analysis looks at 'unhappy', where 73 mismatches were identified.

A review of the mismatched pairs of stock replies containing the word 'unhappy' and their original comments revealed three types of mismatch, which are described in Table 5.7 and accompanied by quantities for each type.

Table 5.7 Description and quantities of three types of reply–comment mismatch

Type	Description	Quantity
MIS	Where the use of 'unhappy' represents a complete mismatch with a comment that is entirely or mostly positive	16 (22%)
MAT	Where the use of 'unhappy' is appropriate as far as the comment is concerned, but mismatches with the positive score	8 (11%)
PM	Where the use of 'unhappy' partially mismatches the comment, which has positive and negative elements	49 (67%)

The most striking result here is that 16 of the 73 mismatches identified are complete mismatches, as illustrated by the following example:

Comment: Excellent service. I've been attending this practice for over the last 30 years and have never been disappointed with the service and professionalism of any of the staff.

Reply: Dear Patient, Thank you for your comments. I am sorry to hear that you have been unhappy with the service you have recently recieved from our practice. I was very concerned to hear of your experience and would been keen to speak to you in more detail about this. Please can I ask you to contact us on the number below. Kind Regards [NAME]

A reason for this particular mismatch is suggested by the fact that the stock reply was posted 292 times on the same date, where a central administrator representing multiple dentist practices seems to have been using the stock reply to respond to NHS Choices comments en masse. In their effort to complete the task quickly, the staff member appears to have posted the reply without properly reading the comment. The presence of the word *disappointed* in the comment, even though used positively by the patient to say that they *have never been disappointed*, may also explain the error, suggesting the mismatch might be the result of the staff member scanning comments – manually or using software – for sentiment-indicating lexical items.

This interpretation is supported by other examples of complete mismatch where comments contain wording that is ostensibly negative when scanned out of context. For example, in one comment the patient describes *an unpleasant and cold experience*, but is referring to their old practice in a review praising their current practice: *Great NHS dentist.. pleasant surprise!* In another example, the patient notes their dentist is so *popular* that *it can be difficult to get an early appointment*, quite the opposite of damning with faint praise, especially in a comment which describes the dentist as *very experienced and skilful*, as having *done exemplary work* and as someone they would *recommend ... to anyone*. There is no reasonable interpretation of this comment that would justify the characterisation of the patient as 'unhappy'.

Complete mismatches do not only occur when patients' words are taken out of context. They can also occur when staff interpret constructive feedback in a positive comment as negative feedback. For example, in a positive comment which describes a *lovely dentist* and where the patient explicitly states *being perfectly happy with [their] treatment*, the commenter also goes

on to provide constructive feedback which they demarcate from their personal experience account with the headings *Good Points* and *Bad Points*. The *Bad Points* include observations such as there being a lack of disabled access, but nothing to contradict the patient's claim of *being perfectly happy* or to justify the staff member's interpretation in their reply of the patient as being *unhappy with the service*. While patients' personal feelings and evaluation of health services often amount to the same thing, this is not always the case, as this example demonstrates, and in not recognising the distinction when this occurs, staff risk using unsuitable stock replies in response to comments.

In two-thirds of cases where stock replies containing 'unhappy' do not match comments, a partial mismatch occurs. This involves the use of a stock reply that only reflects the negative aspects of a mixed comment that makes both positive and negative points, even though overall the patient is 'likely' or 'extremely likely' to recommend the service to friends and family. Typically, partial mismatches occur when patients praise medical staff while criticising administration staff. Therefore, one reason for staff responding to mixed feedback as if it were completely negative might be because respondents are often administration staff who may be interpreting feedback in terms of the parts that are most relevant to their role. This may be the reason for the stock reply used in the following exchange:

> **Comment:** brilliant dentist, but nobody ever seems to answer the phone. The dentist that I see has been brilliant, in the work carried out and the advice given. Fortunately I live local so I can pop in to get an appointment as the phone is very rarely answered.

> **Reply:** Dear Patient, Thank you for your comments. I am sorry to hear that you have been unhappy with the service you have recently recieved from our practice. I was very concerned to hear of your experience and would been keen to speak to you in more detail about this. Please can I ask you to contact me at the practice. Kind Regards Practice Manager

Another reason for staff using stock replies suited to negative comments to respond to mixed comments, a practice that suggests a greater interest of staff in the negative aspects of feedback, may be the tendency for staff to have a problem-solving management attitude when responding to feedback. This would explain the reply in the example above which interprets the patient as being 'unhappy' and asking them to get in touch, even though the patient

lessens the negative effect of their single criticism (about the phone not being answered) by describing how this is not in fact a problem for them. The example considered here shows that stock replies can be heavy-handed and not well suited to dealing with feedback that is more complex than simply being either completely negative or completely positive. Individualised responses, on the other hand, can reflect the nuance of evaluation in feedback more effectively, as this excerpt from a unique reply illustrates: *We were pleased that your experience was mostly positive - the exception being the appointments process*.

Responding to mixed comments, especially ones that are primarily positive such as that quoted above, as if they are negative is problematic as it suggests that criticism is valued more than praise. In the long run, this type of mismatch might have the effect of discouraging patients from sharing the positive aspects of their healthcare experiences if the responses they receive indicate that staff are only interested in hearing about the negative aspects.

The final type of mismatch between stock replies containing 'unhappy' and patient comments is when patients' represented feelings seem to match staff interpretation of these. In this sense, the mismatch is not between the reply and the free-text part of the patient feedback, but between the reply and the questionnaire results, where patients have indicated that they would be likely to recommend the service to friends and family even though they have written a negative comment.

One reason for this may be that patients have completed the questionnaire incorrectly. Another possibility is that patients' criticism of one aspect of a service does not mean that they do not feel good about the service overall. For example, in one comment a patient describes how the cancellation of evening and weekend hours would make it difficult for them to arrange a dentist appointment because of their own working hours. The patient notes: *These apointments are in high demand so not sure why these are being cancelled*. It seems reasonable for the staff respondent to infer from this that the patient is 'unhappy' with the change. However, that the patient has indicated that they would be likely to recommend the service to friends and family suggests they are happy with the service overall. In this way, a more accurate response might be to reflect the specific complaint of the patient being unhappy with access to the service, rather than general discontent suggested by the wording *unhappy with the service*, as this is not consistent with the fact that the patient would likely recommend the service.

Mismatches between the emotion or evaluation reflected in staff replies and the questionnaire scores of patient feedback suggest the usefulness of looking at scores in combination with free-text comments. This might help give staff a more complete picture of patients' attitude to services.

So far, this section has looked at clear-cut instances of mismatch between stock replies and patient comments. However, this does not account for the fact that how much a reply matches a comment will likely vary in terms of degrees of compatibility. Further, aspects of the language that influence compatibility are not established, known markers that can be automatically identified. To investigate different ways that replies and comments can mismatch, a qualitative analysis of 50 sample stock replies (the same random group used in Section 5.2) and their original comments will be carried out in the remainder of this section. This analysis will also consider instances where stock replies and their comments are well matched.

One way in which stock replies are often found not to match patient comments is in the style of the language used. This is illustrated by the following excerpts from a comment and its reply:

> **Comment:** The nursing staff were excellent, and although I had to stay longer than I had hoped, this was not an unpleasant experience. The food was not great, but I was not exactly feeling my best and did not have much of an appetite … All in all I could not have paid for better care.

> **Reply:** Thank you for taking the time to give us your feedback on your experience during your admission. We will ensure that it is shared with the teams concerned, which will undoubtedly be gratefully received.

The commenter makes disclosures about their state of mind (*longer than I had hoped*; *not exactly feeling my best*) and personal tastes (*The food was not great*), and uses colloquial wording (*All in all*). This all contributes to the effect of a personal style which is at odds with the detached style of the respondent who uses corporate lexis (*ensure*), official-sounding language (*the teams concerned*) and careful phrasing which produces a guarded effect (*will*

undoubtedly be gratefully received). This mismatch in style draws attention to the generality and formality of the response which makes clear that it is a stock reply.

Style mismatching might be explained by text type mismatches, where a particular type of reply might be suited to some types of comment but not others. For example, a reply that could be classified as an organisation promotion text, like the one in the following example, might be compatible with a celebratory comment consisting primarily of praise, but does not seem appropriate when used in response to this personal experience story:

> **Comment:** ward 20. My day at the hospital began when I reported to the ward, everyone treated me in a polite manner, introducing themselves telling what they needed to know and sometimes why. Throughout the day my dignity was respected by all staff at every level. If hospital treatment is necessary I would recommend [NAME]. Thankyou

> **Reply:** Thank you for your kind remarks. We appreciate all feedback we receive, as it helps us to continually improve our services.

Here, the staff member uses a stock reply that consists almost entirely of a statement about how the practice values *all feedback*, when in fact an individualised reply would arguably have been more suited to responding to the patient's specific experiences being recounted in narrative form.

The comment–reply mismatch of text types shows how staff and patients can sometimes be communicating at cross-purposes, which is also illustrated by other examples from the sample. For example, to respond to a patient's personal experience narrative, the staff member uses a stock reply that primarily consists of a message inviting the patient to nominate *the team/the person you were kind enough to write in about* as part of *a quarterly At Our Best Awards scheme*. This suggests an attitude where staff value positive feedback as a rating, a measure of success that can be translated into award nominations, and therefore something of reputational value to a health organisation. However, such a reply seems to lose the sense where, by telling a story, the patient is primarily sharing their personal healthcare experiences, not rating a service.

The tendency of staff to overlook the point of why some patients provide feedback is shown with another example where the staff member uses a stock reply which includes text inviting the patient to become involved in a scheme called *Patient Stories*. According to the text, this scheme represents a means by which staff can get to *know more about our services from the point of view of those who received them*. This stock message fails to acknowledge the fact that the patient is already sharing information about services from their *point of view* through the comment they have posted on NHS Choices. When staff respond to patients sharing their stories using a stock reply that invites them to share their stories, this suggests the invitation has been made for effect rather than because staff are genuinely interested in what patients have to say. To effectively demonstrate the latter, staff would need to produce individual replies that respond to specific aspects of patients' narratives.

Staff responses that address different parts of patients' feedback can be found among unique replies. In one example, the respondent states from the outset their intention to engage with the details in an individualised way: *Your comment is a detailed one so we will try to deal with each point in turn*. They then proceed to do just that, sometimes clearly signposting the points in the feedback they are addressing: *Firstly, regarding the [NAME]'s A&E department ... Regarding the delays you experienced ...* The addressing of detail is combined with relational work, such as supportive evaluation, *so you did the right thing by bringing your grandson*, and expression of concern for the patient's feelings, *we do hope that this response has gone some way to explain the unusual set of circumstances our emergency department experienced on Saturday*.

Another type of mismatch identified in the sample is a temporal mismatch which occurs when staff use a tense to describe events in a comment that does not match the tense used by the commenter. This is illustrated by the following example of an exchange where the writer of the stock reply has erroneously anticipated that patients' accounts of negative experiences would now have ended, hence their use of past tense *had*. However, the commenter's use of the continuous present tense (i.e. *becoming*) indicates that the reported negative experiences are ongoing:

> **Comment:** My husband and I are becoming more and more upset and depressed
> **Reply:** We are sorry you feel you had a negative experience

While this temporal mismatch relates to a small detail at a textual level, it has the potential to have significant negative relational implications. The comment has been left by the partner of a patient who was in hospital at the time of their writing, and expresses the couple's concerns about conditions on the ward. That they have chosen to express themselves via NHS Choices rather than resolve the matter directly with staff at the hospital may be an indication of their ongoing need to find someone to listen to them. If this was the case, then the temporal mismatch would most likely have added to their sense of not being listened to.

As well as highlighting ways that stock replies mismatch comments, the review of the stock replies and comments sample has revealed examples where stock replies can be said to suitably match comments. These include conversational features being used in stock replies, similar to the kind that are often characteristic of the language of patient comments (these features were described in Section 5.3 of this chapter). The language of stock replies can also match that of comments in other ways, such as by using the kind of persuasive techniques that are usually associated with promotional discourse. This is the case with one stock reply identified in the sample which uses statistics to represent patients' approval of a practice: *We have some great patients and 9 out of 10 believe we offer a great service*. This seems to match a comment to which it responds, as illustrated by the following excerpt from that comment:

> The TV is always telling us that there are so many problems nowadays but this surgery I feel is always putting their patients first and that is how I have always felt. Even talking to other patients in the waiting room I have never heard anyone complain or say they will change their doctor.

Here, the patient uses the slogan-like *putting … patients first*, the kind of promotional maxim that is traditionally associated with the commercial world. They also use persuasive strategies, such as representing a criticism so that they can refute it and citing the testimony of others who support their viewpoint. While this use of language in patient comments may not be typical, it nevertheless illustrates the pervasive influence of enterprise culture, and suggests a way in which impersonal, corporate-style language may in fact help engage the patient. Such matching is arguably consistent with effects identified by accommodation theory, where interlocutors are said to converge on aspects of each other's language to establish social closeness (Giles and Ogay, 2007). Although use of stock replies suggests that

staff will not be actively converging on the language of the patient, even accidental matches may help to enhance engagement.

Sometimes, matching in the sense of a certain type of reply representing a suitable response to a certain type of comment may entail a comment–reply pairing that in other respects mismatches. This is the case when formulaic stock replies are used in response to highly critical comments that may represent a verbal attack on staff. In a comment from the sample, a patient makes personal accusations against staff (*The reception staff consists of 3 lazy people gossiping*) and uses strong emotive language (*they treat you like filth*) in a way that arguably goes beyond what might be said to constitute reasonable, constructive criticism. The patient also notes that they have changed to a different practice. The comment thus seems motivated more to denigrate the practice and warn others away.

In cases of such comments, a response that matched the patient's style would not be appropriate. Instead, the staff member has replied with a polite stock response:

> We take patient satisfaction very seriously and we are sorry that you are not happy with the service we have provided to you. If you would like to discuss your comments raised in this review, please contact the surgery to arrange a meeting with the practice manager, where we will try and resolve the problems raised in your review.

Matching in terms of pairing certain types of reply to certain types of comment also applies to positive feedback. Several examples from the sample demonstrate 'good practice' language use in stock replies that seems well suited to responding to praise. In everyday conversation, a conventional response to praise might be an expression of gratitude, positive feeling or both. However, when responding to praise that occurs as part of feedback, it is also arguably important for staff to acknowledge its usefulness to them, as is done when language like the following is used:

> It will encourage us to continue giving the utmost best care to our patients

> It does much to encourage our team here at [NAME] Practice and motivates us to maintain standards

By reporting that praise encourages staff, stock replies can convey not only the fact that positive feedback is valued but also that it has a useful purpose. This may help patients feel that their sharing of positive feedback is worthwhile, which contrasts with the likely effect of stock replies that focus on the negative while ignoring the positive aspects of patient comments, considered earlier in this section.

This section has highlighted how using stock replies to respond to patient comments en masse risks complete comment–reply mismatches occurring. It has also highlighted how mismatching can vary in degrees of compatibility. Mismatching – whatever the degree of the mismatch and whether it is informational or stylistic – can potentially have adverse implications in terms of how staff are able to maintain good relations with patients through their responses to feedback.

Looking at mismatches in this section has also revealed problematic implicit attitudes of staff. These include the view that negative feedback merits more attention than positive, and that the evaluation parts of patients' comments are all that matter. The latter is demonstrated by the way staff use binary categories to recap comments in terms of being good or bad even when comments consist of narratives that provide a more nuanced representation of patients' healthcare experiences. Such mismatching has highlighted the inadequacy of stock replies when feedback takes the form of personal experience stories.

This section has also identified ways that staff use of language in stock replies contributes to mismatching, specifically by making language choices that do not take into account the style or genre of patient comments. However, considering replies relative to comments has also highlighted examples where the language of stock replies can be well suited to use in response to particular types of comment.

5.6 Conclusion

As noted in the introduction to this chapter, advice provided on the NHS Choices website about how to reply to feedback includes the recommendation not to use stock replies. Such advice is generally supported by the findings in this chapter which highlight the tendency for the language of stock replies to be impersonal. To some extent, this impersonal quality reflects the copy-and-paste nature of replies based entirely or mostly on reused text, a practice that likely indicates the management purpose of completing a job quickly to save

time. However, this effect is compounded by the typical linguistic choices of staff when they produce stock replies, which reflect a managerial register, foreground the sense in which an administrative task is being performed and position staff and patients in a service-transactional relationship, where staff are organisational actors and patients service users.

The use of highly formulaic language characteristic of stock replies is likely to create an automated-processing effect which suggests that staff view all patients the same, and is therefore, by definition, non-patient-centred. A feature of stock replies that is especially oriented to patients in general, rather than individuals, is the corporate-like organisational value statement, which implies a general audience. In this chapter, these statements have been identified as evidence of a marketised discourse, and their presence suggests that corporate norms have a stronger influence than patient-centred care on how staff use language when they produce stock replies. However, this does not necessarily mean they will be negatively evaluated by patients, many of whom could potentially view them as appropriate features of an expected customer service register.

In this chapter, stock replies were found to consist of a limited number of discourse functions each served by similar kinds of language, which reflects their general-purpose nature as reusable texts. Despite this, linguistic variation between different stock replies suggests ways that the language used can be more or less impersonal; for example, through pronominal choice, use of different sentence types (e.g. passive, active, imperative, conditional) and lexical selection. While certain linguistic choices can help personalise the style of stock replies, without individualised content this will not overcome the generally impersonal effect created by this reply type. That said, where there is an argument for using stock text – such as to save time when a lack of resources prevents staff from writing more individualised replies, or to address common issues using standardised responses – certain wording choices can at least help reduce the impersonal effect of stock replies.

A fundamental problem with stock replies is more than the effect of particular linguistic choices or the lack of individualisation; it is also the uncaring attitude of staff that is suggested when they produce obviously copied and pasted replies. A possible view of patient feedback is that it is a collaboration between patients and staff, where experience-based and institutional knowledge is shared between the two parties. However, when staff respond to patients' accounts of their personal healthcare experiences with stock text, this implies a more

disconnected relationship. The uncaring attitude of staff is particularly illustrated by the examples of mismatch identified in this chapter, such as when stock replies intended for negative feedback have been used for positive feedback. Such errors raise a question about the point of the feedback on NHS Choices – if healthcare staff do not have the time to reply to feedback properly, do they have the time to reflect and act on that feedback?

Chapter 6: Analysis of Unique Replies

6.1 Introduction

An opposite tendency to the standardisation associated with stock replies in Chapter 5 is individualisation, a practice identifiable with the reply type that is the focus of this chapter, unique replies. Unique replies are staff replies that do not match any other reply by more than 30%, the threshold up to which texts arguably share words by chance (see Chapter 3 for details). On this basis, unique replies likely represent individually written texts (i.e. rather than copied and pasted texts) intended for one-time use. The unique replies dataset examined in this study consists of 24,761 texts and 3,633,155 words, which constitutes about 19% of the staff replies corpus.

The individually written nature of unique replies, particularly in a context where the use of stock text is commonplace, suggests several hypotheses about the language of unique replies. These include that unique replies will involve considerably more variation than stock replies, and therefore provide a window on the broader possibilities for how language can be used to respond to feedback; and that unique replies will generally represent more personalised language use, as suggested by the fact that staff have taken the time to individually write replies when use of stock text exists as an option. In light of this second hypothesis, a question that might be posed about unique replies is whether they still contain language use or discourse that makes them impersonal.

Considering the extent to which these expectations are confirmed or challenged by evidence of staff language use will form part of the analysis of unique replies presented in this chapter. As with stock replies in Chapter 5, the analysis here will address the two research questions, RQ2 and RQ3 (see Section 1.7), which relate to the interpersonal function of staff language use and discourses that may be reflected in staff replies.

A major difference between stock and unique replies is that the latter are not subject to the skewing effects of text reuse that prevent the use of traditional corpus-assisted discourse studies (CADS) methods (see Section 3.4. Therefore, keywords form the basis for the analysis in this chapter. A general keyword analysis of the top 50 keywords of unique replies is presented in Section 6.2. The chapter is then organised around keywords, or practices

suggested by keywords, deemed to be salient for answering the research questions, as follows.

Section 6.3 presents an analysis of the keyword *unfortunately*, which considers, in particular, evidence of politeness practices revealed by use of this word. Section 6.4 then presents an analysis of the keywords *new* and *demand*, and by highlighting discourses reflected in unique replies, it particularly addresses part (b) of RQ3. The final analysis section in this chapter, Section 6.5, looks at the use of third-person address strategies (suggested by social actor collocates of the keyword *this*, e.g. *gentleman*, *contributor*), which relates to how staff position themselves in relation to patients and is therefore particularly relevant to RQ2. The chapter then concludes with Section 6.6, which reflects on the findings relative to expectations and the thesis research questions.

6.2 Keyword analysis of unique replies

This section investigates the language of unique replies by analysing keywords (see Section 2.5.4 for a definition of keywords). To calculate keywords, unique replies were compared to a reference corpus consisting of the other reply types, using Log-likelihood. The top 50 keywords identified were divided into categories based on theme and function which were determined by a review of concordances,[9] and these are displayed (with frequencies in parentheses) in Table 6.1 below (see Appendix 1 for statistical information).

Table 6.1 Keywords of 'unique replies'

Theme or grammatical category	Keywords (frequency)
Explanation indicators	there (7,238), which (9,431), due (2,583)
Auxiliary verbs	is (36,951), has (9,650), being (3,197), may (5,880), was (10,017)
Comparison	as (23,524), but (9,163), however (5,066), other (3,502), than (3,533)
Prepositions	in (30,342), of (51,414), over (3,268), up (4,046), before (1,562)

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[9] Some of the keywords were used in multiple contexts so I have categorised them according to their most typical function in Table 6.1.

Adverbs	not (23,801), only (3,632), unfortunately (2,978)
Determiners and pronouns	a (55,412), an (13,350), this (37,079), their (7,856), some (4,938), no (2,839)
Appointments	appointments (13,802), appointment (12,411), day (8,081), system (7,039), waiting (3,090), see (5,897), hours (2,338), seen (3,251), week (2,124), reception (5,641), available (4,634), access (3,325)
Medicine	prescription (1,668), medication (1,585)
Problem/solution	new (4,756), problem (2,827), demand (2,105)
Social actors	patients (26,803), doctor (5,863), doctors (4,191), GPs (2,227), receptionist (1,941)
Punctuation	" (3,536)

An initial consideration of the keywords in Table 6.1 reveals two main thematic patterns. These are the recurrence of keywords representing an explanatory function, particularly those in the 'Explanation indicators' and 'Auxiliary verbs' categories, and the high number of words that represent the topic of 'Appointments'.

For example, the explanation-indicating keywords *which* and *due* typically mark the provision of further information in replies to feedback. These occur when staff provide details about actions they are taking: *we are now trialling changes **which** include offering more face to face appointments*. In a review of a random sample of concordances, *which* was revealed to be used in relative clauses in 98 out of 100 cases. Relative clauses are typically used to provide additional information, as in the preceding example where the words following *which* provide further details about the noun *changes*. When the word *due* is used, in 92% of cases it is part of the phrase *due to*, which introduces causal information: *we could not accomodate you **due to** the Nurse being off sick*.

Other keywords indicating explanation include the 'to be' verbs – *is*, *was* and *being*. These entail stating something to be (or to have been) the case, such as when *was* is used by staff to refer to past events or actions as part of explanatory narratives: *The self-checking machine **was** added to take pressure off a busy reception*. A review of 100 random concordances in unique replies found *was* to be used as part of an explanation in 64 cases. 'To be' verbs are sometimes used to modify other verbs in order to create tense or aspect. This function as an

auxiliary verb is shared by another keyword, *has*, the use of which also often indicates explanation: *a large amount of money **has** been spent over the last 3 years.* In this example, present perfect *has been* is used to represent past action in relation to outcomes in the present, for the purpose of explaining how investment in medical equipment has taken priority over décor improvements. A review of 100 random concordances found *has* was used as part of an explanation in 60 cases.

The finding that individualised messages are likely to contain a higher amount of explaining language (when compared to the other reply types) is directly related to patient complaints. As identified in Chapter 4, unique replies are strongly preferred for responding to negative feedback. This is illustrated in Table 6.2 which presents unique replies divided into the proportion that were used in response to different patient ratings of services. These score ratings are based on how patients responded to a questionnaire question about how likely they would be to recommend a service to friends and family.

Table 6.2 Results of 'family and friends recommendation' question linked to unique replies

Score	% of unique replies
(1) Extremely unlikely	58.81%
(2) Unlikely	11.63%
(3) Neither likely nor unlikely	7.70%
(4) Likely	6.59%
(5) Extremely likely	15.26%

That about 70% of unique replies are used in response to feedback that provides a negative score – feedback that is therefore more likely to represent complaints – is perhaps to be expected given the evidence of explaining language associated with this reply type. This suggests that staff are taking a more conscientious approach to addressing complaints than would be the case if copied and pasted stock explanations were in more common use to respond to negative feedback.

While grammatical keywords reveal how explanation represents a characteristic function of unique replies, the dominant lexical category 'appointments' (making up nearly a quarter of the keywords) suggests a common theme in replies that is likely the object of explanation.

This is illustrated by use of the keyword *appointment* when a staff member provides explanation to address a patient's claim about there being a lack of appointments:

> I understand that a same day **appointment** was offered but that that was not convenient for you

Referring to the patient's specific situation makes this an individualised response, but the fact it has been individually written does not necessarily mean it will contain a personalised explanation. In fact, that 'appointments' has been highlighted as a recurring theme suggests that many unique replies may entail staff reproducing standard explanations about practice procedures even though the responses represent individual pieces of writing. This is illustrated by the following examples containing the keyword *hours* (from the 'Appointments' category) and its strongest collocate *48* (279 – hereafter, frequencies are displayed in parentheses), which has an MI score of 7.575:

> With regards to prescription, we require **48 hours** to prepare your prescription

> The turnaround time for repeat prescription is **48 hours**

> It does take **48 hours** to turn a prescription around

These similar responses likely reflect the same repeated issues being raised in feedback, which suggests the restricted possibilities for language use in a feedback-response situation. In this way, there may be a case to be made for copying and pasting parts of replies, at least, where a single explanation covers a common recurring complaint.

In addition to providing explanation, staff can also take an argumentative stance when they produce unique replies, as revealed by the keywords *but* and *however*. *But* and *however* are adversative conjunctions which indicate that arguments are being made. They tend to involve the statement preceding *but* or *however* containing either an assertion or acknowledgement and the statement following representing the opposite. For example, *This has been discussed with our reception staff, but, unfortunately, no-one could recall the incident*, where an acknowledgement of the patient's complaint is followed by an assertion that there is no evidence to support its merits. The following example represents the use of *however* in an

argument that has the reverse structure to the previous example. Here, the author of the reply first asserts that patients are satisfied and then concedes that more can always be done to improve things:

> Our recent survey shows that the majority of patients are satisfied or very satisfied with the service we provide, **however** we are always open to discussion on how we can further improve the service we offer

That these two conjunctions occur as keywords highlights how the practice of making an argument is a distinct feature of unique replies. These arguments typically entail staff disagreeing with patients. When a disagreeing statement is made after an adversative conjunction, this is potentially face-threatening, as suggested by the above example for *but* where, by stating that nobody *could recall* the events of a patient's complaint, there is arguably the insinuation that they never happened. An alternative interpretation of this could be that the respondent has not had or taken the time to more thoroughly investigate what happened, which highlights an issue with unique replies, namely that to respond individually to feedback may involve activity in addition to producing a written response. When an acknowledging statement is made after an adversative conjunction, this can function as a concession, and therefore arguably mitigates potential face threats, as is the case with the *however* example above. That said, the concession here is vague and general, as if expressing 'nobody is perfect'; in contrast to the preceding assertion and its reference to a concrete survey as evidence of the practice doing well, this suggests an overall effect of disagreement.

The keywords *but* and *however* are overwhelmingly more frequent in unique replies than stock replies, with *but* occurring over 13 times more often in unique replies (9,163 instances compared to 683 in stock), and *however* over seven times more often (5,066 compared to 697). This likely reflects the greater freedom permitted to make arguments when staff produce unique replies. Such freer use of language associated with unique replies is also reflected in other keywords that help reveal how this reply type can be characterised in terms of wide variation in register.

Several keywords suggest a tendency for informality to occur in unique replies; for example, the keywords *some* and *only*. The vagueness of *some* suggests that it is more likely to be a feature of unplanned conversation than writing. This impression is supported by the finding

that *some* occurs 1,718 times per million words in the spoken part of the British National Corpus (BNC) compared with 1,462 times per million in the written part. *Some* as a marker of informality is illustrated by the following example from a unique reply: *It sounds like there were **some** struggles on the way but the secretary came good for you.* The effect of an informal register here is also created by the colloquialisms *sounds like* and *came good*.

The keyword *only* also arguably indicates informality, as suggested by its occurrence in the phrase *only just* (83 times in unique replies); for example, *Apologies for the late reply, I have **only just** worked out how to respond!* The expression *only just* refers to the very recent past in a way that suggests the immediacy of conversation. In this example, the omitted pronoun at the start and exclamation mark at the end add to the informal effect. The fact that *only just* occurs 25.5 times per million words in the spoken part of the BNC compared to 9.7 times in the written part also supports the interpretation of this phrase as a conversational feature.

In contrast to these examples of staff adopting an informal register when responding to feedback, unique replies include evidence of very formal language use, as revealed by collocates of *it is*,[10] which occurs 8,162 times in the dataset representing this reply type. These collocates highlight repeated use of *it* as a dummy pronoun when a particular attitude is being expressed, as in *it is disappointing* (188), *it is unfortunate* (151), *it is appreciated* (114), *it is pleasing* (78), *it is reassuring* (45) and *it is regrettable* (36). A slightly less formal form of these expressions is represented by use of the contraction *it's*, though this occurs notably less frequently, which helps confirm the function of the dummy pronoun here as a marker of a formal register; for example, *it's disappointing* (8), *it's unfortunate* (6), *it's appreciated* (1), *it's pleasing* (5), *it's reassuring* (2) and *it's regrettable* (1). The extent to which the adjectives in these examples represent formality arguably depends on what less formal alternatives are available to staff in the discourse.

For example, more informal alternatives for *it is reassuring* might be those that use first-person pronouns to attribute the expressed attitude to a person or group, such as *I am reassured* or *we are reassured*. These are arguably more informal compared to expressions that use dummy pronouns where the lack of directness and clarity about who, if anyone, has

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[10] *It is* was identified based on *it* being the strongest collocate of the keyword *is*, when calculated using Log-likelihood, with *it* having an LL score of 22,803.806 and occurring in the L1 position 95% of the time when using a 3L and 3R range.

experienced reassurance is suggestive of a distance and reserve associated with formality. As *I am reassured* and *we are reassured* occur only four and three times, respectively, in staff replies, this suggests use of the *it is* construction is the preferred choice for conveying the attitude represented by the lemma 'reassure'. This is less the case with *it is disappointing*, where the forms *I am disappointed* or *we are disappointed* occur 88 and 134 times, respectively, and suggest greater competition between these different ways of expressing disappointment. This draws attention to use of the dummy pronoun *it*, emphasising the formal style, particularly when an informal alternative is the more common choice. In the case of *it is regrettable*, slightly preferred alternatives are *I regret* (56) and *we regret* (98), but the most strongly preferred way of expressing regret in unique replies are the forms *I am sorry* (3,641) and *we are sorry* (3,182). That a more personalised, less formal option occurs widely in the discourse emphasises the sense in which use of the dummy pronoun in *it is regrettable* represents an exaggerated formal style, one that produces a disembodied, impersonal effect.

To personalise replies and show they are a real person, staff may want to adopt an informal style. However, as they are writing in a professional capacity, they may also find themselves drawn to a standard NHS register, perhaps one characterised by a formal or managerial style such as that observed in stock replies in Chapter 5. Another explanation for the differences in register identified above is that staff might be trying to match the register or form of the patient when they produce individualised replies. While investigating the extent to which this is the case would require a systematic analysis of feedback and replies, and therefore falls beyond the scope of the present thesis, accommodating patient language use in this way is suggested by the following excerpts from a comment–reply pair:

> Commenter: The dentist and staff don't really get into chit chat which can be tricky when you are nervous but this is ok as treatment is good value and quick!

> Respondent: Im sorry that you didn't engage in conversation with any of out staff, the dentist is often preoccupied with the treatment, however your assisting nurse should be chatty enough

In this example, the informality of the reply is conveyed by the use of a contraction, two typos and the informal word *chatty*, which reflects the conversational style of the comment,

as particularly exemplified by the sequence *don't really get into chit chat*. The choice of *chatty* in reply seems in particular to mirror the wording *chit chat* in the feedback.

Another feature of unique replies is the use of language to indirectly express feelings and attitudes. Writing original replies means that staff can express themselves more freely than is possible when being constrained by the kind of boilerplate elements that occur in stock replies. However, staff are still likely to be influenced by professional behavioural norms, which would explain the need for attitudes and emotions to be conveyed indirectly. This is evidenced by the keyword *unfortunately* when used by staff as a discourse marker (see Section 6.3 for fuller discussion of this keyword). The following example represents typical use of *unfortunately* when it follows *but* (273). Here, it functions pragmatically to express the attitude that staff are stating the final word on the matter:

> The comments you make are serious, but **unfortunately** we can not respond to anonymous complaints made online

This use of *unfortunately* produces an impolite effect that suggests unaccommodating officiousness. While semantically regret is being represented, the surrounding words convey the view that it is regret for an avoidable situation caused by the patient's actions. However, the patient's action of leaving anonymous feedback is not problematic, despite the suggestion that it is by the way staff use *unfortunately* in this example. Staff could quite easily *respond to anonymous complaints*, as many often do, and as is recommended in the NHS Choices advice on how to reply to feedback on the website (see Section 3.3).

Staff feelings and attitudes are also indirectly expressed when they recap details from patient feedback. Recapping content from patient feedback is a personalised act insofar as it demonstrates that staff have at least read and are directly addressing what patients have said. Recapping is often evident when staff use the keywords *being*, *receptionist* and " (quotation marks). The following examples of *being*, identified via several of its strongest collocates, illustrate this practice:

> seen (147) – I am sorry that you had a delay in **being seen**

> rude (67) – they are not **being** obstructive or **rude** they are simply doing their job

answered (47) – the perception that telephones are not **being answered** is mistaken

Staff use *being* to recap actions or behaviour described in feedback. The way that they respond to patients' take on events can express their attitudes without the need for these to be explicitly stated. This is illustrated by the above example where the author refutes the claim that staff were *rude*, observing that *they are simply doing their job*, which conveys the view that the patient is being unreasonably critical. Another rebuff of a patient's perspective is represented in the third example, though language is used here in a way that seems intended to be polite. For example, the use of the definite article *the* instead of second-person possessive *your* reduces the potential effect of the patient feeling they are being directly countered, and euphemistic *mistaken* is used instead of the more face-threatening 'wrong'.

Recapping is also evident when the keyword *receptionist* collocates with words such as *rude* (68), *spoke* (45) and *felt* (46). How replies are worded when staff recap commenters' representations of receptionists as *rude* can convey different attitudes. This is the case with the difference between the wording *felt the receptionist was rude* and *the rude receptionist*, where the first treats the patient's representation as their subjective view, and the second treats it as accepted fact.

Recapping is also marked by the use of quotation marks, another keyword of unique replies, such as when staff highlight specific words patients have used in order to challenge this use; for example, *I'm not sure by what criteria you are describing us as "dire"*. Using quotes to recontextualise the language of patients in this way helps to distance staff from such negative representations. Here, quoting seems to function as a device to control the perspective in the narrative of events reported in patient feedback, an action known as perspectivisation (Tátrai and Csontos, 2017). The ironic or distancing use of quotes in this example suggests the word *dire* is an exaggeration, which has the effect of calling into question the patient's credibility in using such a word.

Several of these examples illustrate how personalisation indicated by recapping does not necessarily mean personalisation in the interpersonal sense of being more familiar and friendly. Personalised replies could potentially produce an opposite adversarial effect, as suggested by the following example, where a staff member disputes a patient's claim: *At no time was the Receptionist rude or unhelpful.* However, despite this potential for personalised

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replies to be impersonal, I would argue that engaging with patients on an individual level is still generally preferable to the use of copied and pasted stock replies.

Another way that keywords distinguish unique replies is by the way they reflect a use of language that is generally more upfront about the causes of issues that have led to patients' complaints. This is the case with the keyword *demand* which, on reviewing 100 random concordances, was found in 78 out of 100 occurrences to be used in representations of NHS practices and hospitals struggling to cope with demand. This can perhaps be explained by the distinction between unique replies and the other reply types (used to constitute the reference corpus), where the latter are based on reused text and are therefore more likely to represent deliberate management messaging. That *demand* occurs as a keyword suggests staff producing unique replies might feel less of a need to be guarded than those producing stock replies. This is because the latter tend to involve use of a managerial register (see Chapter 5), which is associated with control and perhaps, therefore, the avoidance of blame or expressions of fallibility that might be suggested by talk of struggling to cope with demand.

In 48 out of 100 cases, based on a review of the concordances of *demand*, staff make some form of reference to the struggle to cope with demand being a wider social issue rather than a problem specific to an individual practice. This is represented by some of the expressions around the uses of *demand* observed in the review of concordances, such as *national crisis*, *ageing population*, *real income per patient* and *dwindling resources*. Such language foregrounds the sense in which the NHS is a publicly funded service that requires the government's allocation of tax revenue to healthcare to respond to changes in population size and people's behaviour. In this way, the keyword *demand* indexes a political discourse about how the NHS is run, as suggested by the following example:

> the extra **demand** and lack of resources in primary care have been well documented in the press

In contrast to the discourse revealed by the keyword *demand* is a marketised discourse, as reflected in the use of the keyword *new*. While the language around *demand* represents problems affecting a publicly funded health service, ones that may be at the root of patients' complaints, the use of *new* in unique replies suggests a solution to these problems. The top 10 lexical collocates of *new* include *system* (971), *premises* (95), *installed* (74), *brand* (41),

building (83) and *computer* (68), words that typically represent the report or promise of new facilities, equipment or processes. For example:

> We have also invested in a **new computer** and telephone **system** both of which we believe will make the practice more efficient for all

Use of the keyword *new* in unique replies reveals the tendency to treat service shortcomings as fixable through innovation and modification. This arguably represents an enterprising view of problems highlighted in patient feedback, which contrasts with the alternative perspective of problems in the NHS being the result of political and social causes, such as public spending cuts and population growth.

In addition to commercial values being represented by use of the keyword *new*, these are also evident in unique replies through the functional use of language; for example, when staff use patient survey results to promote how successful a new system has been:

> 77% of our patients who were recently questioned were happy with the **new** appointment **system**

Citing service endorsement in this way represents an activity traditionally associated with market practice. Evidence of a marketised discourse is also highlighted by the keyword *patients* when collocating with the word *majority* (273, with an MI score of 3.383), as in *The majority of our patients appear genuinely happy to disclose basic information*, which similarly cites patients' endorsement, but also serves the function of delegitimating patients' complaints by implying that negative feedback represents the unreliable view of a minority. In a review of 100 randomly selected concordances of *majority*, 53 cases were found to be used in this way.

The link between words and discourses is not always as clear-cut as the previous example might suggest. For example, when the keyword *other* collocates with *practices* (270, with an MI score of 5.245), it often does so when staff are favourably distinguishing the service they provide from that provided by other practices, as might be expected with marketised discourse. However, these words also collocate when staff highlight ways that practices are similar, which may be for the purpose of affirming that different practices are part of the

same common national health service, suggesting they are not in competition with each other. Examples of these different uses are as follows:

> We are always open throughout the day unlike **other Practices** which close their doors at the end of surgery

> We aim to use NHS resources responsibly and in common with **other** GP **Practices** follow CCG guidance

This second example also demonstrates how staff may be using the reference to other practices as a defensive strategy. It does this by claiming that their actions are the same as all other staff across the NHS, which means they represent standard practice beyond their personal control, and reflect normal behaviour that does not merit complaint.

Less ambiguous evidence of a marketised discourse is provided by the use of persuasive techniques for promotional purposes. These are indicated by the collocation of *occasion* with the keyword *this* (708, with an MI score of 3.692), where staff often use the expression *this occasion* to implicitly frame the reported negative experiences of patients as one-offs; for example, *I understand on this occasion that there may have been a breakdown in communication*. This implies that a situation resulting in the patient's negative experience is an exception to a norm where the service is good and does not usually involve such breakdowns in communication.

Compared with more personal second-person alternatives, use of the determiner *this* can also produce a depersonalising effect, as with use of *this comment* rather than *your comment* and *this patient* rather than *you.* Replies from the service area GP practices that contain *this comment*, *your comment* and *this patient* were linked to original comments based on the scores provided by patients in response to the question, 'How likely would you recommend … to friends and family?'. The proportions of these are displayed as percentages in Table 6.3. I have focused only on GP practices here, which represent the highest amount of unique replies (65%), in order to control for service area variation while looking at variation based on score ratings.

Table 6.3 Compared uses of *this* in GP practice replies, relative to quantitative ratings

	(1) Extremely unlikely	(2) Unlikely	(3) Neither likely nor unlikely	(4) Likely	(5) Extremely likely
Unique replies	58.81%	11.63%	7.70%	6.59%	15.26%
this comment **(610)**	68.23%	11.09%	5.12%	4.05%	11.51%
your comment **(1,509)**	62.06%	11.54%	8.85%	6.88%	10.67%
this patient **(597)**	75.53%	14.17%	4.66%	2.33%	3.30%

The phrases *this comment*, *your comment* and *this patient* are all most commonly used to reply to patient comments that provided a score of 1 (where they were very unlikely to recommend the practice to friends and family). Even though unique replies overall are more likely to include replies to feedback rated 1 (58.81% of unique replies), the phrases identified here are even more likely to occur in replies to very negative feedback. The distancing *this comment* is slightly more likely to be used than the personalising *your comment* when responding to very negative feedback (indicated by a score of 1 – 'extremely unlikely'). More notably, *this patient* is used 90% of the time in response to all feedback with negative scores (1, 'extremely unlikely' and 2, 'unlikely'). This indicates that staff prefer to use third-person *this patient* when feedback is negative, which may be part of a strategy to depersonalise patients and discredit their feedback, for example:

we suspect that **this patient** has mistaken a friendly smile for a 'smirk'.

It is unfortunate if **this patient** feels that we came across as being 'too busy' to address his concerns, we operate an open door policy and welcome constructive comments

Another third-person address form, *this gentleman/lady*, which occurs 41 times in unique replies, is always used to reply to criticism, for example:

This lady has indeed been a patient with us for many years, but during that time has failed to attend a number of appointments. This has amounted to a considerable amount of lost surgery time.

The use of third-person reference in this way indicates that commenters are being written *about* rather than *to*, which implies the targeted audience of this message are members of the public who may be reading the replies. *Lady* and *gentleman*, when used in this context, are arguably pseudo-polite forms (Holmes and Sigley, 2001, p. 254), intended to legitimate what are potentially antagonistic responses.

This section has shown that, while unique replies often do represent personalisation, the fact that responses to feedback have been individually written does not prevent them from also including language use that is likely to produce impersonal effects. This goes slightly against the expectation that unique replies would be fully identifiable with personalisation. Further evidence against such a characterisation is the fact that no personal pronouns – such as 'you', 'your', 'we', 'our', 'I', 'my' – were included among the keywords. This suggests that, generally speaking, the language of unique replies is not more personalising than the other reply types; at least not as much as might have been expected.

In this section, I have used a keyword analysis to provide a fairly general account of staff language use when they produce unique replies to patient feedback. The remainder of this chapter will present a closer analysis of different phenomena highlighted by this keyword analysis, including (im)politeness, reflected discourses and (im)personalisation, suggested by the keywords *unfortunately*, *new* and *demand*, and *this* (combined with social actor words), respectively.

6.3 Negotiating the line between politeness and impoliteness: the case of 'unfortunately'

This section takes a closer look at the keyword *unfortunately*, briefly considered in the previous section. The word *unfortunately* is interesting because it can be used in a variety of ways that have different politeness effects. In this respect, it provides a useful entry point at which to investigate in more detail the relational aspects of staff language use when they respond to patient comments.

The approaches used in this section involve a review of concordances, in the first instance, to identify the different ways staff respondents use *unfortunately*, followed by an analysis of

collocates of *unfortunately*. The purpose of this second approach is to triangulate the findings from the review of concordances with linguistic evidence using a principle-based method.

One hundred random concordances of *unfortunately* were selected (using the 'show in random order' function in CQPweb), reviewed and then grouped into categories based on their meaning and function. These categories, the percentage of uses of *unfortunately* that apply to each category and example concordances are displayed in Table 6.4.

Table 6.4 Meaning and function categories of *unfortunately* based on 100 concordances

Meaning/function category (% of sample)	Concordance examples
1. Expresses regret for things being outside staff control (64%)	*call in. We do operate from an older style building and* **unfortunately** *access is only available by the stairs to the upstairs waiting areas*
2. Expresses regret for behaviour of addressed patient or a third party (i.e. indirect criticism) (26%)	*opportunity to review instances where things appear to have gone wrong.* **Unfortunately** *we can not investigate anonymous complaints. We would encourage*
3. Expresses regret for things inside staff control (i.e. indirect apology) (6%)	*an additional comment above after we spoke with you to explain.* **Unfortunately** *you did experience a far longer wait for your telephone appointment*
4. Expresses sarcasm (4%)	*finished the last toilet roll so the staff can replace them.* **Unfortunately** *we do not have the manpower to inspect toilets after every use*

The review of concordances finds that use of *unfortunately* can be distinguished by the object of regret that is expressed when staff use this word. Almost two-thirds of the time the object represents a situation that is arguably beyond the control of staff, such as the physical shortcomings of a practice's premises, as illustrated by the example in Category 1 of Table 6.4. In just over a quarter of cases in the sample, the object of regret is someone's behaviour

or actions, typically the patient's when they post comments anonymously. This is represented by Category 2 of Table 6.4 and can be interpreted as a form of indirect criticism. More infrequently, 6% of the time, uses of *unfortunately* occur when a staff member expresses regret for a situation that is within their control (Category 3). Here, use of *unfortunately* may form part of an apology, but when there are no other indications of apology (as is the case with the reply from which the example in Table 6.4 is taken), the word seems to be used strategically by staff to acknowledge that a patient may have been inconvenienced but without admitting fault. In 4% of cases, use of *unfortunately* is for sarcastic effect (Category 4).

The primary focus of this section are Categories 1 and 2, which make up 90% of how *unfortunately* is used. Starting with Category 1, on close examination this is revealed to consist of examples that are distinguished by the variety of issues that may be beyond staff control. For example, the object of regret indicated when *unfortunately* is used may be an unexpected event or an existing condition, as represented respectively by the following:

> **Unfortunately** our public toilet was blocked and we also had a water leak coming from the flats above

> **Unfortunately** we are unable to see patients until their details have been registered onto our clinical systems

Even though both represent regret for situations that are beyond the control of staff, the nature of these two situations will likely entail different evaluations by patients. In the case of unexpected events, patients are more likely to be assuaged by staff members' expressions of regret than they are when these apply to procedures or policies that, while perhaps not in the power of individual staff members to change, occur by design. This may be a design that the individual staff member agrees with and would not want to change; in which case, *unfortunately* could be said to function as a pragmatic marker where the word expresses regret in a general sense intended for politeness purposes. This is more clearly demonstrated when *unfortunately* accompanies a truth claim, as in the following example:

> At times of peak activity the staff do have to work exceptionally hard and **unfortunately** delays can sometimes occur

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The use of *unfortunately* here seems to serve the function of acknowledging and justifying the patient's perspective while at the same time expressing sympathy and politeness. However, use of *unfortunately* as a pragmatic marker may not always necessarily encourage an evaluation of politeness, as suggested by the following example:

> In regard to the patient alerting system, then **unfortunately** this does need to be at a reasonable volume in order for patients who are hard of hearing do not miss their appointment

In this example, the text that surrounds *unfortunately* represents an argument in support of a situation that has been the object of a patient's complaint, namely the volume level of a *patient alerting system*. In suggesting that reducing the volume would negatively impact more vulnerable patients (i.e. those *who are hard of hearing*), this could be interpreted as an insinuation that the feedback is unreasonable. In this way, the expression of sympathy when *unfortunately* was used in this example is not warranted here, which suggests its inclusion may be intended to create a slightly sarcastic effect. This might be evaluated as impolite by the patient, an effect that could be avoided by removing the word *unfortunately* from the sentence.

Uses of *unfortunately* where the objects of regret are situations beyond staff control appear to exist on a politeness–impoliteness cline. How much a patient may be likely to evaluate use of the word as polite or impolite can depend on the nature of the situation that is beyond their control. In the previous example, staff cannot change the fact that there are *hard of hearing patients*, but they do have agency when it comes to judging what they consider an appropriate volume level for the *alerting system*. In other situations, the amount of control staff possess is less open to interpretation. This is the case in the following example where use of *unfortunately* expresses regret for something desired not being achieved:

> We have recently applied for funding for building changes including adding power assisted doors which **unfortunately** has been turned down

That the staff member has tried to take action to improve services for patients, and that this has been prevented by the action of a third party (making it something they clearly have no control over), suggests use of the word here is more likely to be interpreted as a genuine

expression of regret, and therefore more polite than not. In general, the use of *unfortunately* when staff are reporting on actual actions is more likely to convey honesty than reporting on hypothetical scenarios which might seem like making excuses.

In 26% of the concordances reviewed, *unfortunately* expresses regret for the behaviour of the addressed patient or a third party (represented by Category 2 in Table 6.4). With this use of the word, it is not a question of what may be beyond staff control but what staff expect to be within patients' control. In this way, the regret conveyed when staff use *unfortunately* in fact represents an indirect criticism of patients, as the following example illustrates:

> Thank you, **unfortunately** this would have been better sorted via the practice through the complaints procedure. I can not comment on discussions held in consultation rooms with doctors [NAME] Practice Manager

Here, the object of regret is the patient's failure – by posting a comment online – to follow what the staff member deems to be the correct procedure. As a result of this, the staff member refuses to engage with the patient's complaint, which is illustrated by the example that represents their response in full. Unlike the use of *unfortunately* represented by Category 1, the use of *unfortunately* for purposes of criticism does not vary between likely polite and impolite evaluations. As a marker of criticism, *unfortunately* will invariably be construed as impolite when used in this sense. However, the degree to which it may be experienced as impolite will likely vary depending on the explicitness of the criticism. In the following two examples, the criticism conveyed via *unfortunately* varies in degrees of indirectness, the first representing more indirect criticism than the second:

> **Unfortunately** we can not investigate anonymous complaints

> In this instance the patient describes treatment that isn't recent and **unfortunately** hasn't remembered the facts correctly

The first example conveys that the patient has acted incorrectly. It does this via the implicature created by the staff member stating a rule (i.e. non-investigation of *anonymous complaints*) in the context of responding to a complaint, despite this being contrary to NHS Choices' own guidelines about patients being entitled to leave feedback even if they are also

following the complaints procedure (see Section 3.3). Although still expressed indirectly, the staff member in the second example is more explicit about what they are criticising the patient for: not *remember[ing] the facts correctly*. This insinuates that the patient is untrustworthy – based on either their ability to remember or tell the truth – and it is therefore likely to be more face-threatening than the first example where it is only their behaviour and not their character that is being criticised.

In addition to reviewing concordances to identify meaning and function, a collocation analysis of *unfortunately* was also carried out. The aim of looking at collocates is to identify whether patterns in the language (using a principle-based approach) corroborate the findings above, as well as to highlight any differences. The top 30 collocates of *unfortunately* were identified using Mutual Information and allocated to thematic categories; these are displayed in Table 6.5 (see Appendix 2 for statistical information).

Table 6.5 Collocates of *unfortunately* as it occurs in unique replies

Theme	Collocates
Causes of problems	unavoidable (93), unforeseen (115), human (84), administrative (245), funding (430), peak (255), delays (581), failed (303), without (1,811), knowing (348), none (144), no (2,839), tend (117), occur (236)
Words indicating cause	due (2,583), led (223)
Time	occasionally (264), sometimes (1,565), occasions (563), occasion (896), today (511)
Hedges	seems (345), appears (317)
Common grammatical	does (2,376), but (9,163), there (7,238)
Other	common (241), session (255), sooner (225), unable (2,051)

Grouping the collocates into themes reveals that many of those allocated to the theme 'Causes of problems' corroborate the findings of the concordance categories. The collocates *unavoidable*, *unforeseen*, *human*, *funding*, *peak*, *occur* and *tend*, plus *no* which often occurs with 'control' (i.e. 'no control'), all relate to the use of *unfortunately* to express regret for things beyond staff control. For example, *unforeseen circumstances*, *human error* and *funding issues* are causes of problems that may give patients a reason to complain and

represent the object of staff regret. Other collocates in this theme also relate to the other main use of *unfortunately*: to express regret for the behaviour of the addressed patient or third parties. These are *without* and *knowing*, which often occur together (e.g. *unfortunately without knowing any specific details it is difficult for me to address this issue*).

As well as the collocates that corroborate the main meaning and function categories, there are those that reflect the topic that has been a primary focus in this analysis: politeness and impoliteness. These include the hedges *seems* and *appears* (e.g. *unfortunately, there seems to be some confusion*) which are characteristic of linguistic politeness, and the bluntness of *failed* (e.g. *unfortunately you failed to attend*) which seems likely to offend when used to describe patients, as it is in the majority of cases as a collocate of *unfortunately*.

A pattern revealed by collocates that was not identified by the review of concordances is the tendency for *unfortunately* to occur with representations of the unusualness of occurrences that may be cause for complaint. This is indicated by the collocates *occasionally*, *occasion*, *occasions* and *sometimes*, which suggest that *unfortunately* can be used as part of a persuasive strategy when staff express regret for a negative situation that they want to represent as untypical. For example:

Unfortunately we do <u>occasionally</u> fall below the high standards we set ourselves

The word *occasionally* seems to be used here to present a healthcare practice as typically successful, and in a way that suggests a promotional discourse. This was similarly observed in the previous section in relation to the keyword *practices* and its collocates *majority* and *other*, and when *occasion* occurs as a collocate of the keyword *this*. In the example displayed here, the staff member's reference to setting themselves high standards implies that this is beyond even the standards of the NHS, which suggests an exceptional self-view as might be expected of corporate enterprises. While use of *unfortunately* in this example may not produce a particularly strong polite or impolite effect, the self-regarding nature of its use is probably not likely to engage patients who have experienced first-hand what the writer means by *fall[ing] below … high standards*.

Collocates also help highlight how *unfortunately* is used with respect to sentence structure. The most frequent of the collocates identified is *but* which occurs as a collocate 273 times,

and 95% of these are in the position immediately to the left of *unfortunately*. The word *but* is an adversative conjunction that presents one proposition alongside another to make a particular point or argument. In the following example, *but* presents the opposition between a claim about staff efforts and a claim about the unpredictable nature of patients' health conditions:

> We do try to keep the appointments to time, <u>but</u> **unfortunately** some patients do have complications and need extra time

This example represents a defensive argument where the second claim is intended to excuse any shortcomings associated with the first. The word *unfortunately* is used to express regret for the second claim while conveying that it is something that cannot be helped. That *unfortunately* is closely linked to the argument structure of a sentence arguably has implications for how it may be evaluated in terms of politeness. Whether the patient evaluates its use as polite or impolite may largely depend on how much they accept the argument being made. In this way, the interpersonal effect of the language use presented in the example may depend entirely on the argument proffered, which suggests the use of *unfortunately* here may be redundant.

Another use of *unfortunately* is for sarcastic effect, which has been allocated to Category 4 in Table 6.4 when the word is clearly used for this purpose. While *unfortunately* as a feature of sarcasm was only identified in four out of 100 random concordances (where sarcasm was clearly in evidence), it represents a striking use of the word. Such uses of *unfortunately* involve a deliberate impoliteness – or mock politeness (Taylor, 2015) – strategy, as in the following example:

> We are also **unfortunately** unable to control how steep Thorncliffe Road is

This excerpt comes from a reply to a negative comment. It seems likely that the use of sarcasm here would antagonise the addressee. However, by occurring in a reply to somewhat unreasonable feedback, it is arguably a justified response. The original feedback evaluates a practice based on unfair criteria; that is, it would require a major undertaking to resolve: *Surgery is fine for people who can walk but the location could be better, not on a steep slope*. In this way, a sarcastic response seems good-humoured, and this may help staff to seem

relatable to members of the public reading the post, though perhaps not to the person who provided the feedback.

In this section, analysis of the use of *unfortunately* in unique staff replies has demonstrated how the same word form can serve multiple functions and have very different relational effects, which occur on a politeness–impoliteness cline, when staff respond to patients' comments. This dynamic use of the word reflects a context of staff responding to online feedback that can be characterised in terms of uncertainty. Use of *unfortunately* can reflect situations in which staff are expressing their lack of power, but when used to implicitly criticise patients, it can form part of an exercise of power, particularly when staff are refusing to investigate comments left anonymously. It should perhaps be noted, however, that both uses of *unfortunately* here do serve a common function: that of offsetting criticism.

The uncertain power situation of healthcare staff, in particular the non-clinical staff who typically (though not exclusively) respond to online comments, can be explained by several factors. These include their role as gatekeepers who have the power to help or withhold help when patients leave comments (e.g. as shown when staff treat anonymous comments as a reason not to investigate patients' claims); their more subservient role as customer service staff whose performance may be subject to the scrutiny of the public and their managers; and the general situation of a nationalised health service where local service needs are subject to the constraints of government spending decisions.

6.4 Competing discourses: NHS as a public service versus NHS as a group of individual enterprises

This section presents an investigation of two discourses suggested in Section 6.2 by the keywords *new* and *demand*. These are discourses in the sense of being ways of representing reality which, it can be argued, are linked to different ways of looking at the world. The two different ways of looking at the NHS suggested by the keywords *new* and *demand* are, respectively: that the NHS is made up of a collection of individual enterprises and that it is a single public service entity. The rationale for linking the word *new* to this perspective of the NHS is that, when used to describe actions taken at a local practice level to improve services, as it often is, it represents health service organisations as autonomous and enterprising. The rationale for linking the word *demand* to a view of the NHS as a single public service entity is

that it refers to pressures unique to a state-funded healthcare system (e.g. an increase in patients denoting a need for resources rather than a business opportunity).

If individual keywords can be claimed to index particular discourses, it is first necessary to identify how much those keywords have the meaning that is the basis for linking them to such discourses. To this end, 100 random concordances for each word were reviewed. In 65% of the concordances for *new*, use of the word relates in some way to things that are intended to improve services. The other 35% refer to other uses, primary among these being reference to the situation of registering *new* patients. With *demand*, 96% of uses of this word have the meaning of being a quantity to be handled by health services – one that is typically represented as a problem to be managed.

A closer examination of the 65% *new* and 96% *demand* concordances representing uses of the words relevant to the discourses under consideration provides more information about how these words are used in ways that reflect these discourses. For example, in unique replies, typical uses of the word *new* by staff include to inform patients about new resources, such as new facilities, and new approaches, which may take the form of a new system or training:

> We will continue our search for **new**, improved premises that will allow us to increase our capacity in a more significant way

> We are starting a **new** receptionist training programme which will involve receptionists learning about communication

In the original feedback to the reply from which the first excerpt is taken, the patient reports on their difficulty in getting an appointment: *after 15-30 minutes of continous calling all the appointments for the day are done*. The commenter makes no mention of the facilities, and so the reference to the prospect of *new, improved premises* seems to have a tenuous link to the issue at hand, seemingly made for the purpose of the respondent being able to create an opportunity to promote their practice. Here, the use of language is resonant of advertising discourse, and is almost parodic of such discourse. It seems unlikely that the vague prospect of a new building that may lead to an increase in staff will address the patient's concerns.

A review of the original feedback to the second example reveals that it primarily consists of criticism of a single member of staff: *There is one receptionist who is very rude, and arrogant ... I struggle to understand how someone so consistently bad mannered is allowed to remain at the front reception desk!* By reporting on how something *new* will fix the problem – that is, a *training programme* that will correct staff behaviour – the reply reflects a neoliberal attitude whereby any faults identified lie with individual NHS employees rather than the wider health system and policymakers. Such an attitude is characteristic of marketised discourse, and involves not considering possible other reasons that may have led to the feedback, other than that staff need to *learn ... about communication*.

The examples above show that the word *new* does not necessarily describe a change that has happened, but can refer to an aspiration or something forthcoming. These highlight how *new* not only represents a description of something's age, but is also intricately linked with the idea of an ongoing effort of improvement. In the first example in particular, *new* occurs as part of an expression of an attitude rather than an achievement, where report of the *search for new, improved premises* represents staff being positive.

However, use of *new* is not always positive. The review of concordances highlighted that 18% of uses of *new* entail it being represented as part of a problem, as the following example illustrates:

> We are so sorry that the **new** appointment system is causing frustration and difficulties for several of our patients

While use of *new* here may not convey the same optimism shown with the previous examples, and may bring into question how much it can index a marketised discourse, the fact that staff introduced a *new appointment system* represents an NHS practice acting in an enterprising and autonomous way. This is further illustrated in the next sentence of the reply, which begins: *We are holding a practice meeting on August 15th to try and see a way forward*. This shows that, despite teething problems with the introduction of a new system, the response signals that staff have agency and are taking steps to make things better.

With *demand*, where the word refers to a problematic quantity for NHS staff to deal with, a closer examination of the concordance samples reveals that use of the word can vary in terms

of the attitude of staff to what the word represents. For some staff members, *demand* represents something to be managed, while for others it represents something that is unmanageable, as shown, respectively, by the following two examples:

> To cope with **demand**, our consultants run a clinic on a Saturday, and we are currently advertising for another doctor to work in the department

> We simply do not have enough appointments to meet the current **demand** and working hard to maximise the number we can make available

Despite the different attitudes suggested in these examples, the concept represented by *demand* is essentially the same: an unavoidable problem beyond staff control, which they can either *cope with* or be overwhelmed by, without ever being able to decisively resolve. Reference to *demand* thus reflects the nature of healthcare as a state-funded public service where people who manage health services are at the mercy of government spending choices and the unpredictability of the patient population, in terms of its size and people's medical needs. This contrasts with the enterprising view suggested by use of *new* where new staff, facilities, behaviours and systems might be promised in response to complaints, but none of these can change the unpredictable nature of demand on a public service.

The discourse that entails a view of the NHS as a single-entity public service, as highlighted by use of the word *demand*, sometimes includes representations of it as a nationwide issue:

> There is a national crisis as the **demand** for GP appointments has doubled over the last few years

This example illustrates a point of tension between the public service discourse indexed by *demand* and the individual enterprise discourse indexed by *new*. In many instances, the latter can be presented as a way to deal with the former (e.g. recruit more staff to manage increased demand). However, when demand is represented as *a national crisis*, this suggests that local efforts to be enterprising are likely to be viewed as incommensurate with the problem at hand.

Having established ways in which the unique replies keywords *new* and *demand* link to the two discourses being considered, the remaining part of this section investigates what other linguistic evidence exists for these discourses and what more it reveals about their nature. This was done by looking at patterns in the language of the texts in which *new* and *demand* occur. To this end, subcorpora of unique replies containing *new* (3,445 texts) and *demand* (1,682 texts) were compared, each in turn, to the rest of the unique replies, and keywords were generated using Log Ratio. The top 30 keywords were grouped into thematic categories and are displayed in Tables 6.6 and 6.7 below (see Appendices 3 and 4 for statistical information).

Table 6.6 Keywords from the 'new' subcorpus

Theme	Keywords
Staffing	recruited, recruiting, recruit, salaried, employing, recruitment, appointed
New patients	accepting, registrations, registering
New building	buildings, built, premises, moving, QEII
New equipment/systems	installing, installed, BT, software
Change in progress	teething, transition, relatively
Beginnings	joining, starting, introducing
Miscellaneous	brand, existing, cope, old, increasing

Table 6.7 Keywords from the 'demand' subcorpus

Theme	Keywords
Changing in amount or size	rising, grow, risen, increasing, increases, falling, growing, increased, increase, huge, higher
Unexpected nature of change	exceeds, surge, unprecedented
Causes of/solutions to change	ageing, investment, capacity, resource, finite, supply, recruited, funding, resources, match, winter
Staff perspective of change	cope, struggling, facing, challenges
Miscellaneous	nationally

Many of the keywords from the 'new' subcorpus corroborate the concordance findings for use of *new*. They include keywords that refer to human resources and infrastructure, as represented by the categories 'Staffing', 'New building' and 'New equipment/systems'. They also include keywords that make up the category 'Change in progress', which corroborates the finding that *new* does not necessarily denote perfection and can involve teething difficulties; for example: *With the use of new software, there is inevitably a teething period and thus occasionally mistakes can happen.* That 35% of uses of *new* do not refer to the idea of improvement is reflected by the category 'New patients'.

A notable pattern that emerges from the keywords for the 'new' subcorpus is the high number of verbs, which accounts for over half of the keywords. Most of these verbs represent the actions of staff where they are agents of change, as might be expected in a discourse entailing an enterprising view of the NHS. Many of the verbs have a present continuous form – *employing*, *registering*, *moving*, *installing*, *starting*, *introducing* – which conveys the idea of ongoing improvement. This is arguably characteristic of promotional language use where to represent change as an ongoing enterprise guards against the potential challenges to claims about things that have happened in the past or will happen in the future.

The 'new' keyword findings are also interesting for what they do not include. While three categories already mentioned relate to certain kinds of improvement, such as employing new staff or installing new software, these could be seen as superficial fixes to problems that are more underlying and systemic. Other words that might have been expected among the keywords identified are 'system', 'policy' or 'process' (and their plurals). This preference of staff to talk about localised matters, like staffing and equipment, may reflect their limited power to make more fundamental changes to improve services. Such limits may be attributable to the fact that staff may be bound by NHS-wide policies and practices.

As with the 'new' subcorpus, many of the keywords identified for the subcorpus consisting of texts that contain the word *demand* corroborate the findings from the review of concordances. They include keywords that relate to the idea of patients as a quantity to be handled by health services, as represented by the 'Changing in amount or size' category. The volatile nature of this change is suggested by the keywords in the 'Unexpected nature of change' category, for example *unprecedented* and *surge*, which represents the idea of things being beyond staff control.

Like the 'new' keyword findings, over half of the 'demand' keywords are verbs. However, the majority of these refer to actions that are not the result of staff agency, such as 'increasing', 'ageing' and 'rising'. A characteristic shared by many of these verbs is that they refer to an ongoing state of growth, which, in a context of discussing the struggle to manage *demand*, helps create a sense of a looming problem that is only going to get worse. With the verbs among the keywords that do refer to the actions of staff, for example *facing* and *struggling*, these represent actions in which staff have a passive role, where things are happening to them.

The lack of control associated with texts where staff talk about demand contrasts with the idea of staff taking action and being agents of improvement that is associated with texts where staff talk about 'new' things. While there is this distinct difference, several keywords shared by both the 'new' and 'demand' subcorpora – *increasing*, *cope* and *recruited* – suggest *new* and *demand* share similarities. In fact, these common keywords can be explained by the fact that the enterprising view of the NHS represented by *new* is sometimes presented as the solution to the problem of *demand*, which is a particular issue with a health service that is state-funded. For example:

> The **new** appointment system was introduced to try to **cope** with extra **demand** and provide more access for patients

However, in the main, the keywords for the subcorpora are different, which suggests that the discourse indicated by *demand* represents its own distinct view of the NHS and does not simply serve to represent a problem to which enterprise is the solution.

The use of *demand*, by focusing on a problem, could be said to represent a pragmatic view in relation to NHS services. The same might be said about the use of *new* when used to describe practical solutions, such as recruiting more staff when there is a shortage of appointments. However, when *new* occurs as part of promotional language use, which has been found in some respects to be the case, it may entail a view that is more idealistic. This is potentially problematic when *new* things are presented as silver-bullet solutions to problems in a national health system that are complex and may be beyond staff control (e.g. demographic changes, changes in government spending). In this regard, an enterprising view of the NHS risks

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creating unrealistic expectations for patients, and while the short-term intention may be to reassure patients with details of improvements, in the long term unfulfillable promises will likely lead to greater patient dissatisfaction.

6.5 Audience address strategies using third-person forms

This section examines in more detail the phenomenon of third-person reference to commenters. That 85% of texts in the unique replies corpus contain *you* shows that direct, personalised address is the norm when staff respond to patients' comments. The reasons why staff use third-person forms to refer to individual commenters, thereby deviating from this norm, are the focus of investigation in this section.

In the first instance, the variety of forms that third-person reference can take, and the need to single out those that refer specifically to the patient who has posted a comment and not a third party, has required the manual identification of examples. Third-person forms were identified based on speculating what words might be used and searching these in the corpus; these are listed in Figure 6.1 below with their frequencies in brackets. Low-frequency examples are included to illustrate the lexical variety of third-person reference to commenters in the data.

| this patient (518) | this person (65) | the writer (65) | the person who (53) | the patient who (53) | the author (50) | the complainant (47) | this anonymous (32) | this lady (16) | this particular patient (15) | the reviewer (15) | the poster (11) | this gentleman (9) | this reviewer (6) | the correspondent (6) | the commentator (6) | the individual who (6) | this complainant (3) | the lady who (3) | the commenter (2) | this commenter (2) | this poster (2) | the above person (2) | the woman (2)

Figure 6.1 Third-person forms used to refer to the person who has posted a comment

The different choices of words used to refer to patients in the third person are interesting for the way they can suggest different staff attitudes. For example, *this lady* suggests a patronising attitude where the falseness of a word traditionally associated with politeness is highlighted by the impersonal way the patient is being referred to in the third person. When staff refer to a patient as *the above person*, they represent them as identifiable with the

physical comment as it appears on the screen; this arguably suggests a reductionist, dismissive view of the patient where the patient is only meaningful to the staff member insofar as they have left a comment. The attitude of staff when they use the third-person form *the complainant* is officious, with the word *complainant* formalising the patient's status even though a patient's intention in posting a comment on a review website may be to vent or express themselves without wanting to initiate formal proceedings.

The lexical choices of third-person forms considered seem to suggest an antagonistic view of patients. This can in part be explained by the fact that staff tend to refer to commenters in the third person when responding to negative comments. The majority of the staff replies represented by the list of third-person forms above – 83% – are for the service area GP practices; of the original commenters prompting these replies who completed a questionnaire rating the service, 89% provided a negative rating. However, this does not suffice as an explanation for why staff use the third person, for staff can just as well use direct address to respond to negative comments, as the following example shows:

> This is a very unfair comment on a public website, when **you** have already raised this matter with us directly at the practice

Use of third person cannot simply be summed up as the chilly manner in which staff respond when they receive negative feedback; also, while individual lexical preferences may suggest different staff attitudes, this does not account for their purpose in using the third person when direct *you* would seem a more logical choice. Therefore, the purpose of staff using the third person to refer to commenters will be investigated in this section.

A review of a sample of concordances was carried out. Random concordances of the third-person forms listed in Figure 6.1 were identified: 10%, or as near as permitted, of each of the third-person forms was included in the sample, resulting in a sample of 106 concordances. Two of these were discarded because the words did not refer to patients, leaving a sample of 104 concordances. These concordances were then reviewed and sorted into categories based on their evident purpose. The categories, the percentage of concordances for each category and example concordances are displayed in Table 6.8.

Table 6.8 Categories of evident purpose of referring to commenters using the third person

Purpose	Concordance example
1. To provide procedural advice to commenter and public reader (23%)	*in dealt with in person and in a timely manner. If* <u>this patient</u> *wishes to contact the Practice Manager this will be investigated.*
2. To make a public display of performing appropriate responses (33%)	*practice replied: We sincerely apologise for the service experienced by* <u>this patient</u> *at our reception desk today and would like to thank them for*
3. To discredit patients and/or their comments (38%)	*certain age. I can not comment on an assumed telephone conversation* <u>this person</u> *thinks she overheard. I wish you well with your new surgery*
4. To explain the patient's case to the reading public (6%)	*to treat a patients with respect! The GP practice replied:* <u>This patient</u> *having already seen by ambulance crew on 13th June requested an*

These four categories representing the main purposes of using the third person were allocated by recognising that the third-person reference of the commenter implies an address of the public, and inferring the writer's purpose in addressing the public based on the particular language they use.

In almost a quarter of cases, as represented by Category 1, the purpose of the third person seems to be to give the patient procedural advice while also conveying the same advice to any member of the public who may be reading the comment. In the example in Table 6.8, the staff member provides the advice that the patient needs to *contact the Practice Manager* for the information reported in the comment to be investigated. In using the third-person form *this patient* and implying an address of a public audience, the suggestion is that the advice being given should also be heeded by any other patients who may be reading.

The multiple audience suggested by the Category 1 purpose of using third-person forms – that is, the commenter and members of the public who may be reading – reflects the public

and anonymous nature of online feedback where it is not clear who may be reading, and, particularly in the case of replies, who is writing the texts that appear on NHS Choices. In previous research on the patient feedback linked to the staff replies data primarily examined in this thesis, patients were similarly found to address multiple audiences. For example, the word 'avoid' was often found to be used by patients when advising readers not to use a practice, while in other feedback patients would sometimes specify their intended audience when requesting that their thanks be passed on to individual staff members (Baker, Brookes and Evans, 2019). These changes in audience suggest the potential for uncertainty about who is being addressed, and therefore also relational barriers, when staff and patients communicate via a feedback website like NHS Choices.

Category 2 in Table 6.8 represents the purpose of using the third person in a third of cases. This purpose is to make a display of responding to patients' comments in a particular way, and is inferred on the basis that the staff member is not providing information but performing a relational act. Category 2 use of the third person is typically in evidence when staff are thanking or apologising to patients, as the example in Table 6.8 shows. The inference that staff are making a display of thanking or apologising is based on the fact that the relational purpose of their language use would have been more engaging had the second person been used; therefore, the only explanation for their use of the third person seems to be to draw public attention to their behaviour.

The use of the third person that occurs most often is represented in Category 3, where 38% of the time the evident purpose is to discredit patients and their comments. This purpose is interpreted on the basis that the language surrounding use of the third person involves some form of bringing into question the reliability of the patient and their comment. In the example in Table 6.8, this occurs through the use of language that attempts to cast doubt over whether the events described in a patient's comment actually happened: the *assumed telephone conversation this person thinks she overheard*. The more impersonal use of a third-person form instead of *you* helps create distance between the writer and the commenter, while use of the word *thinks* implies that the patient is wrong.

Addressing a public audience when questioning the reliability of the comment creates the effect of inviting the public to share this view. Interestingly, the writer switches to second person in the sentence that follows (*I wish you well with your new surgery*). This sudden shift

from an attempt to discredit the patient with a public audience to directly addressing the patient as part of an act of well-wishing suggests the latter was meant sarcastically, and produces an impersonal and insincere effect.

The final category, Category 4, represents the purpose of using the third person to exclusively address a public audience to explain a patient's case, which occurs 6% of the time. The purpose of staff here seems to be to relay a narrative to contextualise a patient's comment, such as might occur when staff feel the details of a comment misrepresent a situation by including only part of the story.

While use of the third person represented by Categories 1 and 4 appears to involve addressing the public for the purposes of providing advice or information, third-person use as represented by Categories 2 and 3, accounting for 71% of the sample, is more concerned with identity and relational work. As this is the topic of RQ2 of my thesis, the remainder of this section will closely examine samples from these two categories.

To begin by considering examples from Category 2, a closer review of concordances that represent third-person use for this category suggests variation in the particular identities staff perform when they address a public audience for this purpose. This variation is illustrated by the following two examples:

> I am sorry that **this patient** received a poor response when they tried to ring the surgery in March

> Naturally I am very sorry if **the writer** feels that our usual very high standards of providing excellent patient care has somehow fell short of their expectations on their most recent visit

In the first example, the staff member's description *poor response* expresses empathy for the patient's experience in a way that suggests they are addressing the individual patient as much as the reading public when they use the third-person form *this patient*. Nevertheless, by also addressing the public, the apology being made is more impersonal than it would have been had the staff member directly addressed the patient. The reason for making a display of the apology, given that the staff member also makes efforts to relate to the patient via the

expression of empathy, seems to be to demonstrate taking ownership of the situation. This might be interpreted as the staff member wanting to show their professionalism and could be read as a performance of professional identity.

One argument for this interpretation of the first example is the absence of any alternative explanation for staff use of the third person when use of the second person *you* would be more engaging and more likely to achieve the patient's acceptance of the apology. The purpose of using the third person in the second example is clearer: to perform organisational identity. This is indicated by the use of the plural possessive pronoun *our* in combination with superlatives about abstract entities (*our usual very high standards*, *excellent patient care*), which suggests a corporate-like language. By using such language while addressing a public audience through use of the third person *the writer*, the staff member seems to be making a sales pitch to the public rather than an apology to the individual patient.

In both of these examples, the staff members' use of third-person reference to commenters contrasts with the personalised first-person singular reference to themselves. That they personalise themselves while impersonalising the patients suggests they intend to represent themselves as caring individuals to the public while in the act of apologising. This may be for promotional purposes, but for the intended recipients of the apology, being referenced in the third person suggests they are unlikely to have experienced the staff language use as caring.

The use of the third person for promotional purposes, as the second example demonstrates, may reflect a general influence of enterprise culture, whether in the NHS in particular or public services in general. This does not mean that staff use of language therefore represents a coordinated corporate strategy. On the contrary, the different uses of the third person alone represent the variety of different purposes staff have when they respond to patients' comments. However, use of the third person does provide some evidence of deliberate, strategic language use involving audience address, as shown by the following example:

> Thank you very much to **this patient** for taking the time to share their experience. We are thrilled to hear you are smiling with pride and so glad we could help.

Here, the staff member switches from the third person in the first sentence to the second person in the second sentence; from an inclusive public audience address to an exclusive

direct address. The intention seems to be to draw the public's attention to a piece of good news for the practice (namely, the patient's positive comment), while still engaging the patient by addressing them directly. This example demonstrates dynamic use of third-person reference to the commenter and reflects the staff member balancing writing a personalised response with the public situation in which the interaction with the patient is taking place.

With examples of third-person use represented by Category 3 in Table 6.8, the question is less about whether these represent strategic language use and more about the different ways language is used strategically. The purpose of third-person use represented by this category is that of discrediting patients and their comments. One of the main strategies used by staff to achieve this purpose is deniability, as illustrated by the following example:

> Because we do not know who **this patient** is we can not verify the discussion that took place so we are not sure what happened

The writer of this reply uses the claim of not knowing the identity of the patient as a basis for calling into question the reliability of the patient's account. This strategy of deniability works on the argument that if a person is not known, then there is also doubt over the trustworthiness of what they say. In this respect, anonymity is equated with unreliability. The role of the third person in this strategy is to emphasise the patient's anonymity by representing them in a depersonalised way; that is, as something to behold (*this patient*) rather than as someone who might be spoken to (*you*). It is also to address the public to whom the argument to discredit the patient and their comment is being addressed. The use of this strategy contravenes the NHS Choices guideline that staff not remembering a reported incident 'doesn't mean it didn't happen' (see Section 3.3).

Deniability also extends to denying the patient a full response or investigation of the events reported in their comment, as the following example illustrates:

> We are unable to respond to this review accordingly as **this person** has posted the review anonymously

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That this is a strategy used by some staff members to absolve themselves of the responsibility of addressing issues raised in a comment, rather than a reasonable response to comments that have been posted anonymously, is demonstrated by approaches used in other replies:

> The anonymity of your comment means we can not review the individual records to look at the reasons for the three key questions you have but I will try and respond in general

The writer of this reply still represents anonymity as problematic in that it prevents them from being able to investigate a specific situation, but they do not use this fact as a reason to deny the patient any kind of response. In representing anonymity as a barrier, the previous two examples go against the NHS Choices' guideline that 'anonymous comments' should be treated the same as 'named ones' (see Section 3.3). This is because even referencing the fact that feedback has been left anonymously involves marking it out as different to feedback where the identity of authors is known. Staff reasons for doing this have been highlighted in previous research, where interviews with NHS staff regarding online feedback revealed the attitudes that anonymity represents an obstacle to staff doing their job and casts doubt on the credibility of feedback (Locock et al., 2020).

The public context in which feedback is shared on NHS Choices, and also, therefore, general ethical issues around confidentiality, place restrictions on the extent to which staff should be referring to the specific details of a patient's case in their replies to feedback. In this way, a certain degree of generality might be expected regardless of when staff respond to feedback. By highlighting anonymous feedback as wrong, then, there is the danger that this might discourage patients who want to post anonymously.

Another strategy to discredit patients employed by staff when referring to them using the third person is to make claims that they have acted unfairly, inappropriately or maliciously. In the following example, the staff member suggests that the patient is being unfair by giving feedback about long-past events:

> We are also surprised that **the reviewer** is commenting regarding an incident 6 years ago.

A review of the original comment reveals that the patient refers to an event from six years earlier to contextualise their ongoing health needs and use of the surgery. However, the wording of the reply suggests that the patient is describing something that happened a long time ago, and creates the impression that the patient is complaining for the sake of it. By being selective about what details of the comment they recap in their reply, as seems to be the case with this example, the staff member deliberately misinterprets the comment in a way that reflects unfavourably on the patient. The use of the third person to construct an address of the public, as well as reporting their reaction to the comment (*surprised*), represent an appeal by the staff member for others to share in their sceptical view of the patient.

A further strategy to discredit patients using third-person reference to the commenter involves staff questioning what a patient has said. This can take the form of challenging the veracity of a claim or the choice of words a patient has used, as in the following example:

> We do not understand what **the commentator** means by "they never communicate with patients".

As with the previous strategies, this strategy entails using the third person to address the public which allows anything the staff member says to potentially represent an appeal for public agreement. In addition, use of the third rather than second person allows the writer to represent the patient and their comment as objects to be presented to a public audience for scrutiny. When the staff member questions the accuracy of what the patient has said, the public audience is invited to do the same. In this example, the patient is identified in the third person as *the commentator*. This arguably represents a reductionist view of the patient whose identity as a person with potentially complex healthcare needs is boiled down to their role as a message creator. Likewise, by foregrounding a snippet of the patient's comment using quotes, the staff member seems to be attempting to reduce the wider communicative situation of patients sharing their healthcare experiences to a few questionable words. In this way, the discrediting strategy involves discouraging a view of the commenter as a patient while encouraging them to be viewed instead as a troublemaker.

The examples of third-person use considered in this section, specifically when it involves staff engaging in identity and relational work as occurs with Categories 3 and 4, suggest that staff use language strategically in a way that might be expected of commercial enterprises.

This is especially in evidence through the positive self-representation of staff when they make a display of responding to patients (Category 2) and negative other-representation when they use strategies to discredit critics of their organisation (Category 3). However, the idea that this behaviour reflects corporate public relations strategies is debatable. When using techniques to try to discredit patients and their comments, staff can come across as adversarial, and this often seems more likely to create a negative impression of staff than of patients. Instead of using strategies to try to discredit critics, a more effective promotional technique might be to act in a helpful and dignified manner, even in the face of unreasonable criticism, where such behaviour would likely represent staff and their organisations in a positive light.

6.6 Conclusion

The findings in this chapter confirm the expectation that unique replies represent greater variation in the way staff use language to respond to feedback compared with stock replies. This includes evidence of contrasting formal and conversational registers, as highlighted by the keyword analysis, and variation at the level of individual words, as particularly shown with *unfortunately*. The close analysis of this keyword has revealed the dynamic way staff use language when they produce unique replies. While *unfortunately* can be used to express regret, it is also sometimes used in mock-polite expressions to implicitly criticise patients. That staff do this indirectly suggests compliance with surface professional politeness norms, but it also allows for plausible deniability of having acted impolitely.

Although variation in language use may be a feature that distinguishes unique from stock replies, staff replies as a whole are part of a relatively restricted communicative situation where patients will often report similar issues for which staff will have a limited number of response options. In this way, unique replies can also share many commonalities with each other, as reflected by the dominance of explanation-indicating and appointments-themed keywords. This suggests that unique replies are often similarly used to offer explanations and address issues relating to appointments. The fact that individually written replies gravitate to common functions and topics suggests there may be a case to be made for using standardised replies and therefore stock text.

A hypothesis about unique replies stated in Chapter 1 was that they would represent more personalised language use. While there may be many examples in the data to confirm this, the features of unique replies identified and analysed in this study have revealed a tendency for impersonal language use when staff produce this reply type. The example of *unfortunately* has illustrated this. Another example from the analysis is the practice of referencing authors of feedback in the third person in order to address an imagined public reader. This suggests a strategy to express distance from authors and solidarity with a public reader, typically when staff are responding to criticism and seemingly using language in this way as part of a public relations exercise.

The use of language to manage organisational public image, as illustrated by the third-person reference strategies, has been noted in this chapter for the way it reflects a marketised discourse; market values have also been identified in the promotional tendencies evident in representations highlighted by the keyword *new*. These can be explained by a general trend of NHS marketisation (see Section 1.4), the commercial precedence of the practice of online service reviewing (e.g. hotel reviews) and the NHS Choices advice that staff should use replies as a chance to market their practices (see Section 3.3). Where marketised discourse causes staff to use language in a way that is deliberately impersonal, as suggested by the third-person distancing strategies described, this arguably defeats the patient engagement purpose of collecting feedback in the first place, and raises questions about the purpose of websites like NHS Choices.

Chapter 7: Analysis of Mixed Replies

7.1 Introduction

Findings from the analysis of stock and unique replies, in the previous two chapters respectively, have revealed the tendency for both reply types to involve impersonal language use. Stock replies can be formulaic and perfunctory, and unique replies were often found to include use of language in which staff are implicitly critical of patients. In this respect, stock replies are perhaps too restrained, and unique replies are arguably not restrained enough. This suggests that a notional ideal reply type would be one that strikes a balance between these tendencies. A possible candidate for fitting this ideal is the third and final reply type that will be analysed in this thesis, namely mixed replies.

Mixed replies are staff replies that match other replies within a range of 51–70% (see Section 3.4 for details). This suggests that they are made up partly of reused and partly of non-reused text, and also, therefore, the possibility that they consist of linguistic features associated with both stock and unique replies. The mixed replies dataset examined in this study consists of 22,907 texts and 1,580,455 words, which constitutes approximately 18% of the staff replies corpus. A hypothesis about mixed replies that will be explored in this chapter is that they balance the advantages of stock and unique replies; for example, the consistency and time-saving efficiency of reused text with the personalisation potential of individually written text.

As with the analysis of stock and unique replies, the analysis presented in this chapter will address RQ2, on how linguistic choices position staff, patients and their relationships, and RQ3, on how staff language use reflects different discourses (see Section 1.7.1 for full questions). Findings from this analysis will help shed light on how mixed replies compare to the other two reply types and whether they do represent a balance between them. If they do not represent this ideal balance, then a question this raises is: what other reasons might staff have for producing mixed replies?

This chapter has a simpler structure than the previous two chapters. It consists of two main analysis sections, starting first with Section 7.2, which presents a keyword analysis. The purpose of this is to identify distinct linguistic features of mixed replies, and to use this as a basis for analysing language use and discourse associated with this reply type. However, the

nature of mixed replies is that they consist of reused and non-reused text elements, meaning that linguistic choices are partly based on decisions about how and where to combine these elements. This will be addressed in Section 7.3, which presents a qualitative analysis of variation between sample mixed reply pairs that contain the same reused text. The chapter concludes in Section 7.4, which will reflect on how the findings address the research questions and measure up to the expectations about mixed replies described in this introduction.

7.2 Mixed reply keywords

In this section, evidence of mixed replies as a distinct text type is investigated using a keyword analysis approach. Keywords were ruled out as a method for analysing reused text in Chapter 5 because of the skewing effect of copied and pasted texts. Unlike stock replies, however, mixed replies represent individually produced responses in which reused elements reflect text-level choices to insert or not to edit or remove reused text. In this respect, keywords that may originate from reused text represent individual language use choices (at a discourse level, even if not a psycholinguistic one), which provides justification for use of keyword analysis on mixed replies.

To investigate mixed replies as a distinct text type, a reference corpus consisting of the stock and unique reply datasets (totalling 25,835 stock and 24,761 unique replies) was used to calculate keywords for the mixed replies subcorpus. A review of concordances of these keywords reveals few instances of them appearing in any text that has been obviously reused. This can be explained by the likely tendency for reused elements to consist of formulaic language that is similar across mixed replies (the target corpus) and stock replies (part of the reference corpus), thus reducing the likelihood of such elements being the source of mixed replies' distinguishing features. That mixed reply keywords are more likely to come from non-reused elements provides further justification for the use of this method on mixed replies.

The top 50 keywords of mixed replies were calculated in CQPweb using Log Ratio with a Log-likelihood filter, and a minimum frequency of 3 (see Section 3.4, which explains the rationale for using this statistical measure, and the reasons why different measures are preferable when a corpus contains text reuse). These keywords were identified after manually

filtering out names and numbers, and then grouped into thematic categories, the result of which is displayed below in Table 7.1 (see Appendix 5 for statistical information).

Table 7.1 Mixed reply keywords grouped by theme

Theme	Keywords
Affective Words	impressed (109), thrilled (76), delighted (1,513), appreciation (312)
Evaluation	uplifting (41), glowing (74), reassuring (214), pleasing (259), wonderful (317), complimentary (51), nice (586), fantastic (137)
Getting Well	recovering (465), speedy (255), recovery (977), recover (60), recovered (136)
Medical Terms	urology (131), rheumatology (48), cardiology (145), endoscopy (92), radiology (59), infirmary (166)
Childbirth	birth (276), deliveries (64)
Familial Social Actors	aunt (30), relations (274), brother (45), dad (39), mum (117), father (309)
Other Social Actors	consumer (33), co-ordinator (70), reviewer (132)
Management Terms	champion (32), logistics (36), professionalism (88)
Communication	tweet (25), e-mailing (54), expression (25), circulate (26), circulated (83), words (1,455), forwarded (379)
Speech Acts	congratulations (153), compliment (203), condolences (78), hello (458)
Other	'll (400), bits (52)

The themes in Table 7.1 highlight several patterns, including a notable number of positive keywords represented in the categories Affective Words and Evaluation. Keywords reflecting positive evaluation are readily explained by the high proportion of mixed replies that respond to positive comments. As previously noted in the review of the datasets with respect to metadata in Chapter 4, mixed replies respond to positive comments in 72% of cases (based on comments where score ratings were provided), while stock and unique replies respond to positive comments in 67% and 28% of cases, respectively. An explanation for mixed replies being identifiable with the greater tendency to respond to positive comments, as described in Chapter 4, is that a generic appreciative reply suffices with positive feedback, unlike negative

feedback where an individualised reply to carry out relationship repair work is more justified. However, staff might feel that an entirely stock reply is an inadequate reaction to friendly praise. Therefore, mixed replies could be the result of staff adding some personalised elements to their response to reflect the more personalised nature of positive feedback.

Approximately a quarter of the keywords in Table 7.1 represent indicators of patients' positive evaluation. This is primarily explained by the contrast between mixed replies and unique replies (which represent 49% of the reference corpus), with 72% of mixed replies responding to positive comments, but only 28% of unique replies. While this accounts for the general pattern of positive-indicating keywords, the particular words themselves can be explained by the way in which mixed replies are likely to differ from stock replies. For example, the keywords *thrilled* and *delighted* are effusive when considered next to potential alternative expressions of appreciation like *pleased*. This supports the expectation that mixed replies – replies that combine reused and original elements – are likely to have a more personalised style than stock replies which are characteristically managerial and formulaic (see Chapter 5).

Another way that mixed replies differ from stock replies is that they are more likely to include language tailored to individual comments, as represented by the individualised nature of the keywords *glowing* and *impressed*. The word *glowing* is individualised because it refers to the specific style of a comment more than simply its general evaluative stance which could otherwise be reflected by staff using a word like *positive*. This is illustrated by the following example, an excerpt from a comment described as a *glowing report* in the staff reply, where the listed thanks suggest a use of language in the style of an 'Oscar acceptance speech', as similarly observed in Baker, Brookes and Evans (2019, p. 95):

> I want to thank [NAME] Hospital 's Orthopaedic department staff - doctors, nurses, admin and all staff … I also want to thank the outpatient staff … I also want to thank the consultant … So, again, thank you so much for your kindness, professionalism, excellent care and good humour.

The style of a public demonstration of gratitude seems aptly represented by the word *glowing* which conveys the idea of emitted light catching people's attention. Likewise, the keyword *impressed* refers to an aspect of a specific comment, usually a patient's admiring attitude

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towards the service provided: *We are pleased that you were impressed with the care you received from our staff.*

By being individualised, these keywords can also convey aspects of the implicit attitude of staff when they use them: for example, a self-promotional attitude when respondents selectively reflect the high praise of commenters saying they are *impressed* with a service, but do not engage with aspects of patients' reported experiences when not in the form of a repeatable accolade. This is the case with a reply to a comment in which the patient also expresses appreciation for the caring behaviour of staff, noting they were *compassionate ... didn't rush me* and had *a very kind of manner*, but the staff member responding does not mirror this detail in the same way they do when echoing the word *impressed*. Instead of reflecting the detail of the patient's description of staff behaviour, thereby engaging with their experience, the respondent uses it to make a general value statement, which represents a further opportunity for self-promotion:

> We know how important it is for our patients to keep them fully involved and informed during their consultation and treatment and so your comments are very much appreciated and a testament to the dedication our and professionalism of our A&E team

In almost every instance that *impressed* occurs in mixed replies it is to recap patients' praise. Given that approximately half of a mixed reply is reused text, and therefore likely represents stock text, the space for individualisation is limited, adding to the sense in which staff need to be selective about what detail they choose to reflect. In highlighting the selectivity of staff, mixed replies provide a useful site at which to consider the influence of wider discourses on the language of NHS staff. This is illustrated here by the self-promotional tendency of the use of the keyword *impressed*, which provides evidence of a marketised discourse when staff respond to online patient feedback.

Evidence of marketised discourse in the language use of healthcare staff is also suggested by other 'positive' mixed reply keywords, such as *reassuring*. By representing feedback as *reassuring* – for example, *it is very reassuring when we receive such lovely feedback from our patients* – staff suggest a view of patients as a source of confidence that they are doing their job correctly. This represents a shift from the more traditional status of healthcare

professionals as unquestionable authorities (Brown, Elston and Gabe, 2015; Brashers et al., 2000), to power lying more with patients and their authority as consumers (Fairclough, 1994). The nature of the staff–patient relationship as service provider and empowered consumer is illustrated by an excerpt from an original comment that received a mixed reply in which *reassuring* occurs. Here, the patient lists evaluative points as if providing a formal appraisal, which helps explain the approval-seeking attitude suggested by staff use of the word *reassuring*:

> The ward … was kept immaculate, I was aware of this because I had time, whilst resting, to observe … The Endoscopy unit was very well organised … I was seen promptly

Another pattern evident across the majority of themes highlighted in Table 7.1 is that the keywords reflect the greater tendency for mixed replies to be used in response to comments about hospital experiences. In the mixed reply dataset, 96% of replies relate to GP practice, Dentist and Hospital service areas; a similar proportion of replies in these top three service areas occurs in the stock and unique replies datasets. Almost half of these mixed replies (48%) represent responses to Hospital comments, compared with a fifth of unique replies (20%) and just over a third of stock replies (34%).

The notably higher proportion of mixed replies to Hospital comments compared with the text types that make up the reference corpus accounts for many of the mixed reply keywords, for example those in the Medical Terms category, such as *urology*, *rheumatology* and *cardiology*. A review of collocates of the Medical Terms keywords reveals that typically included among the strongest are words like *department(s)*, *team* and *unit*. This highlights the sense in which these keywords represent areas within a hospital.

Other keyword themes attributable to the relatively higher proportion of Hospital mixed replies include Getting Well, Familial Social Actors and Speech Acts. The Getting Well category mostly consists of keywords based on the lemma 'recover', which are each used in response to Hospital comments more than 90% of the time. Recovery is perhaps more associated with hospitals because people often attend hospitals with serious illnesses or injuries or for one-off procedures where there is the prospect of recovery. With GP and

dentist experiences, on the other hand, which are likely to involve more routine check-ups or ongoing chronic complaints, recovery may be a less clear-cut proposition.

The Familial Social Actors theme can be explained as an indicator of Hospital replies by the fact that commenters are likely to speak on behalf of relatives when they cannot speak for themselves, as in the case of serious illness or death, which are more associated with hospitals than GPs or dentists. The same is the case with the Speech Acts keywords *congratulations* and *condolences*. A review of the concordances of these keywords finds that, in almost every instance, the former is used in response to information about a child being born, and the latter in response to information about someone having died. The Childbirth category in Table 7.1 can also be explained by the fact that this kind of healthcare experience is most likely to occur in hospitals.

A possible explanation for hospital staff preferring to use mixed replies when responding to feedback was previously considered in Chapter 4. To recap, hospitals are significantly larger organisations than other kinds of healthcare services, and are therefore more likely to have an established automated process for responding to online feedback. However, as people tend to be in hospital for very serious reasons, staff might be reluctant to fully reuse stock replies because of their impersonal nature, which would explain the introduction of the kind of individualised elements that result in the greater tendency for hospital staff to produce mixed replies.

Another keyword that is arguably explained by the high proportion of Hospital mixed replies is *circulate*, a word used to describe the sharing of information in a manner similar to how air might circulate around a large space or blood around a complex body of many parts. Typical use of the word is analogous to a hospital, a large organisation consisting of multiple departments and teams within departments, as suggested by the following example:

> we will circulate your comments to the ophthalmology teams in the clinic and on the
> day case unit for them to share with colleagues

However, the past tense form *circulated* is used almost as often by smaller healthcare services like GP practices as it is by hospitals. A reason for this may be that staff at smaller practices are adopting the language associated with larger organisations, which perhaps

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reflects how corporate managerial norms have spread across different service areas. This influence of a managerial discourse is also suggested by the keyword *professionalism*, which occurs both in general value statements (a characteristic feature of stock replies – see Chapter 5) and in recaps of patients' representations of staff behaviour. The dual function of this word across stock and individualised elements accounts for why *professionalism* occurs as a keyword of a reply type (mixed replies) that often consists of both elements.

So far in this analysis, most of the keywords and keyword patterns considered reflect the greater tendency for mixed replies to be used in response to positive and Hospital comments. However, the keywords *circulated* and *professionalism* suggest a feature of mixed replies that can be explained in terms of what makes mixed replies 'mixed'; that is, the fact that they combine reused and original elements, rather than the fact they are favoured as a way to respond to positive and Hospital feedback. This suggested feature could be described as the tendency for mixed replies to be more managerial, as illustrated by use of *professionalism*, a concept of work performance standards originating from management contexts.

In mixed replies, *professionalism* is used both to express organisational values (*All practice team members pride themselves on their professionalism*) and to reflect where patients share these values (*We are pleased to hear that you've been happy with the professionalism of the medical staff*). A reason for mixed replies having a greater managerial tendency is suggested by the multifunctional use of *professionalism*: as composites of reused and original text, mixed replies include many stock elements, such as corporate-like value statements, as well as tailored elements that allow other ways for staff to express management values.

A problem with the suggestion that managerial language represents a distinct feature of mixed replies is that it is based on the limited evidence of two keywords with relatively low frequencies. Therefore, to investigate further evidence of this feature, the remainder of this section presents a short analysis of a second set of mixed reply keywords. In this instance, the keywords have been calculated using only mixed replies to positive Hospital comments (6,474 texts consisting of 434,831 words), and a reference of unique and stock replies to positive Hospital comments (5,627 texts consisting of 504,669 words). The purpose of this is to control for the influence of evaluation and service area on the keyword results, so as to draw attention to features that represent the particular nature of mixed replies as composites of reused and original elements. It should be noted that in looking at only part of the mixed

replies dataset, the results will not be representative of this text type as a whole. However, the aim of producing this second set of results is not to challenge the findings above but to identify further evidence to corroborate those findings or to shed new light on the original set of keywords.

The same measures and filtering processes to create Table 7.1 were used, as well as thematic categories, though in this instance only the top 20 keywords are considered. This second set of keywords is displayed in Table 7.2 below (see Appendix 6 for statistical information).

Table 7.2 Top 20 keywords of mixed replies in response to positive Hospital comments

Theme	Keywords
Affective Words	*impressed* (78)
Evaluation	*glowing* (57), *reassuring* (145), *pleasing* (144), friendly (110)
Getting Well	*recovering* (377), *speedy* (199), *recovered* (100), wishing (99)
Familial Social Actors	wife (119)
Management Terms	professional (149), management (102)
Speech Acts	*congratulations* (126), hi (137), *hello* (209), sincerely (172)
Other	five (63), ease (117), looked (199), shall (97)

Almost half of the keywords displayed in Table 7.2 (those in italics) also occurred in the first set of keywords displayed in Table 7.1. A number of these were previously explained in terms of the high proportion of mixed replies to positive and Hospital comments. For example, *glowing* and *impressed* are positive-indicating keywords. They also highlight the presence of marketised discourse in staff replies, where responding to positive feedback represents a self-promotional opportunity for staff to draw attention to the praise they have received. That keywords like *glowing* and *impressed* should still occur among the second set of keywords suggests the evidence of marketisation represents something distinct about mixed replies; that is, beyond the fact that they include a higher proportion of replies to positive comments.

The idea of mixed replies as distinctly marketised when compared with stock and unique replies is also supported by the new keyword *five*, which in all except one instance occurs in the compound 'five star(s)', as in *Thank you for your five star review!*, where staff self-

promotionally use the limited individualised space in mixed replies to draw attention to the way positive comments reflect their success. The role of 'five star(s)' as a self-promotional device is illustrated by its notably higher frequency when compared with other numbered versions of this compound. This illustrates how it is strongly preferred, as shown in Table 7.3 below.

Table 7.3 Frequency of references in replies to different star ratings

Reference to star rating	Frequency
one/1 star	22
two/2 star*	0
three/3 star*	1
four/4 star*	17
five/5 star*	275

When staff refer to the score rating provided by patients, and therefore the review practice itself, this validates the practice in a way that suggests it is self-serving and circular. In this regard, reviews may help staff feel good about how well they are doing their jobs, but it also detracts from the sense in which the texts from patients, posted on NHS Choices, represent feedback, the purpose of which is to engage with the healthcare experiences of patients.

Further self-promotion is evident with use of another new keyword, *professional*, as in the following value statement: *The staff value giving a personal, professional and caring service*. The word *professional*, like the word *professionalism* from the first keyword set, represents the concept of a minimum performance standard, and in doing so provides an example of how managerialism and marketised discourse are linked. In an NHS context, this can be explained by the fact that a well-managed service is the main 'product' that healthcare staff have to promote.

As well as keywords that corroborate the marketised/managerial feature of mixed replies, the second set of keywords also highlights other distinct features. These include subtle individualisation, as suggested by the Getting Well keywords like *recovering* and *recovered*. When the same keywords occurred in the first set these were explained by the higher proportion of replies to Hospital comments. However, an alternative explanation is needed

now that the same keywords occur even after the service area proportion discrepancy between target and reference corpus has been controlled for. An explanation is provided by considering the context that likely leads to staff producing mixed replies. This context is one in which limited NHS resources force staff to employ time-saving measures, hence the frequent use of stock replies to online feedback, but where the principle of patient-centred care promoted across the NHS also encourages staff to engage in the time-consuming practice of providing a more personalised service. Fairclough (1994) represents this tension in a healthcare context as follows:

> time-consuming conversationalized, patient-oriented methods of healthcare come into conflict with rigid economically imposed institutional structures (such as the regulation five- or ten-minute doctor-patient consultation period). (p. 265)

Staff replies that combine the time-saving measure of reused text with the individualisation of added tailored elements, as many mixed replies do, arguably represent one resolution to this tension. A feature of this may be subtle individualisation, where limited time and space means that rather than directly address the detail of patient feedback, staff may choose to use more subtle ways of conveying that they have at least read comments. This is suggested by use of words based on the lemma 'recover' which occur in both keyword sets, as shown by the following mixed reply example:

> Many thanks for posting such a kind comment and we will ensure that we pass it onto the staff within the departments and wards you mentioned. We wish you well with your recovery.

The language of this reply is general enough to suggest it could be used as a stock reply, but not all health service experiences entail recovery (e.g. patients may have chronic or terminal conditions). In this respect, then, it represents an individualised element which, by occurring as part of a well-wishing statement, may also have a personalised effect. In the example, the wording of 'the staff within the departments and wards you mentioned' also represents a non-specific individualised element, in that the author does not specify which departments the patient mentioned. However, a risk with mixed replies that are overly subtle in their individualisation is that they may seem like impersonal stock replies. This risk is particularly increased when the original comment is notably personal, such as is the case with the

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following example. Here, the commenter reports on their hospital experience *following a serious overdose* and expresses their gratitude for the *kind and caring* staff and their *support through a very traumatic time*. The very personal nature of comments like this one arguably merits a more personalised response than the one provided.

Balancing time constraints and the desire to communicate in a personalised way is also reflected in another feature of mixed replies: the tendency for staff to reuse lexical items that patients have used in their comments to represent their experiences. This feature is highlighted by *ease*, a keyword from the second set which is used to reflect patients' claims of being put or made to feel *at ease*. In all 117 mixed replies to positive Hospital comments which include the word *ease*, this word appeared in the original comment.

The tendency for verbatim recap was also revealed to be evident with keywords from the first keyword set, for example *impressed* and *professionalism*: 44 out of 101 original comments that received mixed replies with *impressed* include either *impressed* or *impressive*, and 43 out of 86 original comments that received mixed replies that contain *professionalism* include *profession**: mostly as in *professional* or *professionalism*. Mirroring the specific way that patients have represented their experiences or perspectives represents a shortcut technique to create a personalised effect that saves staff from the time-consuming and risky task of presenting an interpretation of patients' meaning – a technique also often used in counselling (Schreiner, 2014).

The analysis presented in this section has provided an account of mixed replies based on an interpretation of keyword patterns. A primary finding has been that the high proportion of mixed replies to positive and Hospital comments causes the language of mixed replies to be largely identifiable with the language of 'positive' and Hospital replies. However, evidence of managerialism and marketised discourse has suggested that mixed replies are distinguishable as a reply type beyond their greater tendency to be used in response to positive and Hospital comments.

Carrying out a second keyword search, one that controlled for the influence of evaluation and service area, helped to highlight evidence of this managerial/marketised discourse as a distinct feature of mixed replies. Further features were also highlighted by this second keyword search that can be attributed to the nature of mixed replies as reused and original

text composites which represent an effort to reconcile the tension between NHS resource constraints and a desire for personalisation in healthcare. However, an overall shortcoming of a bag-of-words approach, as represented by keywords, is that it does not allow for analytic engagement with mixed replies at the level merited – that is, the text level – when texts reflect the practice of reused and original elements having been combined. This practice will be considered by the qualitative analysis presented in the next section.

7.3 Patterns of variation in mixed replies

This section presents a qualitative analysis of 100 sample mixed replies which investigates how reused text and unique text are combined when staff respond to patient feedback. An expectation with replies that are part-reused and part-unique is that they combine stock elements with tailored elements, where the former serve routine functions while the latter address the individual details of specific comments. A preliminary review of mixed replies, however, reveals this often not to be the case, as illustrated by the following example:

> Many thanks for your very kind comments. All the staff and partners at [NAME] strive to ensure patients receive the best care and experience.

Consisting of two sentences – routine politeness followed by an organisational value statement – this short reply would seem to represent a stock text suitable for reuse with multiple comments. While this may be the case, it is nevertheless an example of a mixed reply, as can be illustrated by comparing it with another text from the same practice that also occurs in the mixed reply subcorpus (the reused text, i.e. the same words that occur in the same or similar position between the texts, is highlighted in grey):

> Many thanks for taking the time to input your comments. All patient feedback is welcome and all staff at [NAME] work hard to ensure all patients receive the best care and experience.

The words that are different between these two texts – such as the adjectival phrase *very kind* between *your* and *comments* in the first text, the additional value statement *All patient feedback is welcome* in the second text and variation in the wording of *strive* versus *work hard* between the two texts – show that mixed replies do not simply represent individualised

text that has been inserted into stock frames. The differences between the examples suggest changes to the texts have been made for stylistic rather than informational reasons. For example, the inclusion of *very kind* to modify *comments* helps create a friendlier, more personal style in the first text, in contrast to the managerial effect created by the addition of *All patient feedback is welcome* in the second text.

As this example demonstrates, mixed replies are not simply composites of reused and individualised text: they can also involve a process of texts being modified – by words being removed from, added to or amended in existing text – to produce particular effects. In this regard, they are distinct from stock and unique replies because of how they can provide clear evidence of text modification, and it is this practice that forms the basis for how mixed replies are analysed in this section. The approach used treats each separate stretch of reused and non-reused text as the unit at which the language of mixed replies is analysed. The primary focus of the analysis will be on those elements identified as non-reused text because these represent evidence of a deliberate language use choice.

As well as highlighting evidence of choice, the above example illustrates the different effects of that choice which, as already shown, can be analysed in terms of the relational implications of particular language use (e.g. the degree to which it is personalised or impersonal). The link between marked choices, as can be highlighted by variation between mixed replies that include a substantial amount of shared text, and different interpersonal effects can provide evidence of relational work that will be analysed in this section to address RQ2 of the thesis. In the absence of or in addition to these explanations of the effects of staff choices, the style of the language used will also be considered where this suggests evidence of the influence of particular discourses; this addresses RQ3.

7.3.1 Identifying variation and variation types

To analyse variation of the kind illustrated by the example at the start of Section 7.3, it is necessary to identify a suitable sample of mixed replies where each reply pairs with at least one other reply in the sample in terms of having a substantial amount of shared text. To identify such comparable texts, mixed replies from the 50 GP practices with the highest number of replies were searched on a Duplicate Contents list generated in WordSmith 7. This

was in order to identify any duplicates based on a Maximum Difference of 50%, the limit for texts to qualify as mixed replies (see Chapter 3).

Using this approach, pairs of mixed replies with a substantial amount of shared text between the replies in each pair – replies that are likely based on the same source text – were identified for 50 different GP practices. Using pairs of replies from different practices increases the generalisability of the findings (though this is limited by the relatively small size of the sample necessary for a qualitative analysis), and using only replies from GP practices serves to control for any variation in language use that may be attributable to differences between service areas.

The sample of 50 text pairs was then reviewed and coded based on comparisons between the replies in each pair. For this, coding first took the form of distinguishing between fixed reused text – where the same words in the same or similar positions occurred in both replies – and any variable elements – where different wording occurred between the texts. This was followed by a further stage of coding the variable elements where different types of variable element were distinguished. The coding of the sample texts is illustrated by the example pair (TP1 – Text Pair 1 in the sample – The sample can be provided upon request) displayed below as Figure 7.1. The words highlighted in grey represent fixed elements that occur in both texts in the pair. The non-highlighted words represent variable elements and these have been marked up in different ways to represent the different types of variable element. A description and explanation of the different variable element types is presented in Table 7.4 below.

Thank you for your comments on NHS Choices. We take all complaints seriously *and* I would be grateful if **the** patient **who has left this review** could contact the Practice Administrator at [NAME] so that we can discuss this [[further]]. *I* am sorry *for the experience that you have had*. It is good to know that reception are doing a good job, thank you. [NAME] Practice Administrator

Thank you for your comments on NHS Choices. I would be grateful if **this** patient could **kindly** contact the Practice Administrator at [NAME] so that we may discuss this [[in full]]. We aim to offer a high standard of service to all of our patients *and* am sorry *that you have not had a good experience*. [NAME] Practice Administrator

Figure 7.1 Coded example pair from the sample

Table 7.4 Key and explanation of different types of variable elements

Variation type	Visual code description	Explanation
Individualised	Underlined	Any variable element that references a specific comment directly or indirectly (as long as it is clear from the language used that the writer is referring to a particular comment).
Variable stock	Grey highlighted	A sentence or clause of stock text (i.e. can be used with multiple comments and there is nothing to suggest it is individualised text) that occurs in one reply in a pair but not the other.
Repackaged	*Italicised*	Variation where words or the word order of a clause or sentence that occurs in both replies in a pair are different but essentially produce the same meaning or effect.
Expanded/reduced	**Bold**	When words have been added to or removed from a clause or sentence, so that they occur in one reply but not the other.
Near-synonym	[[Within double parentheses]]	Variation where words or word sequences of a clause or sentence that occurs in both replies in a pair are similar but produce distinct meanings or effects.

7.3.2 Analysis of Figure 7.1 example

The effect of the different elements highlighted in Figure 7.1 will now be considered via an analysis of this reply pair. In this example, the fixed elements (grey highlighted) represent stock politeness routines: thanks, a request for further contact, apology (at least in the formulaic sense of using the word *sorry* to convey regret) and a sign-off. These fixed elements include some localised detail – the name of the practice and staff respondent (anonymised here) – but are still general enough to be used in response to any negative comment about this particular GP practice. That the fixed elements in this example are interspersed with different types of variable element suggests that a process of considered editing has been undertaken – rather than, say, a block of individually written text having been added to a block of copied and pasted stock text.

There is only one individualised element across the two texts in the example: *It is good to know that reception are doing a good job*. Although informationally individualised, a review of the original comment to which this is a reply suggests that this does not automatically mean the element is also personalised in a relational sense. The original comment is primarily negative: it includes the title *Terrible Treatment*, with the patient describing how they have *been treated pretty badly* and characterising the behaviour of staff as *laughable*. Therefore, by providing an individualised reply to a minor positive detail, the staff respondent seems to be zeroing in on the one piece of good news while not offering the same particular attention to the reported concerns of the patient.

In selectively only acknowledging what staff have done well, the writer uses language in a way that might be evaluated negatively by the patient as corporate and self-promotional; an impersonal effect that contradicts the expected purpose of personalisation. However, the individual patient's potential evaluation needs to be offset against the possible impression on other audiences, such as people skim-reading several comments and replies on NHS Choices. This may be a factor influencing the linguistic choice of staff here, as focusing on what the NHS is doing well may distract from the more negative aspects of the feedback.

Both of the replies in Figure 7.1 include variable stock elements. These serve the same discourse function of expressing organisational values, though they use different words and occur in different positions. In the first reply, the statement *We take all complaints seriously*

offers reassurance about the attitude of staff towards the institutional process that, in using the word *complaints*, the respondent suggests has been initiated by the patient posting a comment on NHS Choices. A review of the original comment reveals that the patient does not explicitly state that they are making a complaint or express any expectation for their feedback to be acted on as if an official complaint were being made. However, if they are happy for it to be interpreted as such, they may welcome the reassurance represented by this variable stock element.

This is unlikely to be the case with the variable stock element in the second reply in Figure 7.1: *We aim to offer a high standard of service to all of our patients*. As a claim about ongoing values that contradicts the reported experiences of the patient (e.g. the statement in the patient's feedback that they *continue to be treated like an idiot*), this is likely to produce a jarring effect. It also suggests that the managerial performance of stating the values of the practice is more important to the staff member than the interpersonal benefits of not stating these values.

Another observation about the variable stock elements in this example is that, as they are both value statements, they could just as well have reused the same wording. That they do not occur as fixed elements might suggest that the writer has not been able to settle on a single way to make claims about organisational values. An alternative explanation might be that, given the similar effect of the two statements, the writer has changed the wording in order to create an impression of an individualised response rather than one that has been copied and pasted.

The example pair also includes 'repackaged' elements. The wording *sorry for the experience that you have had* in one text and *sorry that you have not had a good experience* in the other represent slightly different ways of effectively saying the same thing: the apology preceding the reference *the experience that you have had* implying that it was not a good experience. Such variation might be explained as change for the sake of change, perhaps as a way to avoid the impersonal effect that can be associated with verbatim text reproduction. That the wording is being changed in this way where apology is being expressed might also represent an attempt to avoid an effect of insincerity, as would likely be produced by a copied and pasted apology. This interpretation is supported by the fact that the two replies were posted

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within 20 minutes of each other, and therefore would have been displayed in close proximity on NHS Choices, where both recipients may have been likely to read each other's reply.

Another variable element type in the example is that which represents expanded or reduced wording (depending on whether words have been added or removed, which is not possible to determine with this data). This includes the adverb *kindly*, which may have been added to the second reply or removed from the first reply to change the degree of politeness expressed; a subtle change in the language to create a different interpersonal effect. Another example of this kind of variation is between the form of the third-person reference to the commenter – *the patient who has left this review* – compared with *this patient*. That the writer uses third-person instead of second-person 'you' to address the patients directly might be intended to draw attention to the fact that the patients have posted negative comments anonymously, perhaps for the purpose of indirect criticism.

The final variable element type identified from the sample and illustrated in Figure 7.1 are near-synonyms, represented here by the choices between the two replies of *further* and *in full* – that is, *so that we can discuss this further/in full*. These arguably indicate a choice of using *further* to represent a proposed discussion in relatively vague and general terms when compared to the alternative choice of using *in full*, which suggests the proposed discussion would entail a comprehensive action. The notion of thoroughness associated with *in full*, and the staff desire to express this, might explain this choice of wording over the potential alternative *further*. However, on the whole, it does not seem likely that this would create a different effect on patients, and using near-synonyms to change the text slightly, at least in the case of these examples, is probably intended to create an impression that replies are individualised rather than copied and pasted.

When the effect of the choices indicated by variation is considered in combination at a text level, there seems to be little notable difference between the replies in Figure 7.1. Both have elements that arguably represent more impersonal choices: the on-the-record official quality of added words in the first reply and the stock value statement in the second reply, which makes aspirational claims that are at odds with the patient's reported experiences. Both also include elements that patients may find reassuring: the statement about taking *complaints seriously* in the first and the similar effect of scrupulousness created by the words *in full* when used to represent the nature of a proposed discussion.

The similar overall effect of different choices between the replies suggests that the writer(s) might as well have used, word for word, the same text to reply to these comments. That they have instead made a series of changes to create particular effects reflects the drive to engage in relational work through their language use and the influence of managerial norms on their language choices. For example, the mention of *reception … doing a good job* in the first reply example may be both about doing relational work (e.g. providing a personalised response) and serving a managerial purpose (e.g. to accentuate the positive).

The analysis of a sample pair presented in this section has illustrated a variety of ways that staff can change reused text to individualise replies, or at least to create an individualised effect. The process of analysing these mixed replies, however, has also highlighted the challenges with interpreting choices indicated by the variation identified. For example, it cannot be known for certain which text is the original, and therefore if a choice has been made to change the text one way or another. Also, there may be other replies based on the same reused text, where other types of change may affect how the ones observed here are interpreted. Therefore, this uncertainty limits the extent to which identified variation can be explained as particular types of choice.

7.3.3 Quantitative findings

In this subsection, patterns in the numbers of the different elements identified above (see Table 7.1), as well as how these occur in combination, will be considered. Of the words that constitute the 50 sample pairs (100 mixed replies) examined in this analysis, 56% represent fixed elements (text shared by replies in a pair) and 44% represent variable elements (where variation occurs between replies in a pair). This 44% of the sample can be subdivided into variable element types, both in terms of the number of words for each type and the number of times each element occurs. The numbers for these two ways of quantifying the variable element types are displayed in Table 7.5. The proportions of each variable element type, as it occurs in the sample, are represented as percentages in Figure 7.2. In this figure, the proportions based on word count are displayed alongside the proportions based on the number of elements.

Table 7.5 Number of words and elements of different types of variable element

	Individualised	Variable stock	Repackaged	Expansion/reduction	Near-synonym
No. of words	1,903	599	278	286	509
No. of elements	61	34	65	78	144
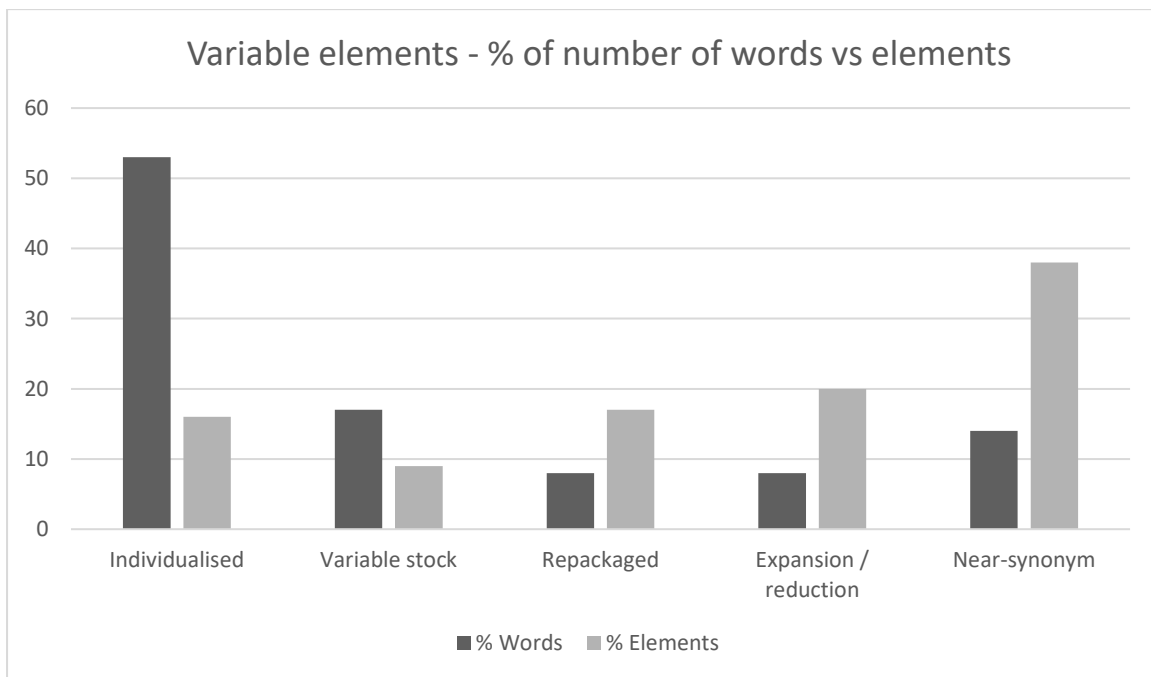
Figure 7.2 Comparison of proportion of variable elements using different measures

Figure 7.2 illustrates how individualised elements are overwhelmingly dominant in terms of word count, amounting to over three times the word count of the next most frequent (variable stock elements) and representing more than half the words of all variable elements in the sample. However, this individualised type has the second fewest when the number of elements is used as a measure. Conversely, near-synonyms are the most dominant in relation to the number of individual elements: 38% of variable elements and almost twice as many as the next most frequent type (expansion/reduction). Near-synonyms are the third lowest variable element type when the number of words is used as a measure.

Overall, Figure 7.2 highlights that a distinction can be made between individualised and variable stock elements as one group and repackaged, expansion/reduction and near-

synonyms as another group of variable element types. This distinction is based on the fact that the proportion of the type belonging to the first group is at least almost twice the size for word count when compared to element count, whereas the reverse is the case for the second group. This can be explained by the fact that individualised and variable stock elements tend to represent inserted continuous text which can involve multiple clauses or sentences. Because what counts as a single element is the space between where one ends and a new one begins, this also explains why the frequency of these element types is lower. The higher frequency of elements and lower frequency of word count for repackaged, expansion/reduction and near-synonym variable element types can be explained by the tendency for these often to relate to single words or short combinations of words, in a way that can suggest ad hoc sporadic edits.

The two groups of variable element types can be summed up as insertions and edits. When the percentages for the element types in each group for both measures (word and element count) are added together, this totals 95% for insertions and 105% for edits (out of a possible 100% for word count plus 100% for element count). These results suggest that the mixed replies represented in the 100-text sample consist of a fairly even balance of the different groups of variable elements identified.

In addition to the frequency of different variable element types in mixed replies, there is the question of how these occur in combination. A review of the sample suggests that texts can vary considerably in terms of the number, type and position of different variable elements, as well as the size of the texts themselves. However, this review of the coded sample does suggest a pattern of a notable number of replies tending to primarily contain individualised elements, as well as a pattern of a notable number tending to contain variable elements that have been classed as 'edits'.

To identify quantitative evidence to support this observation, the number of texts in the sample containing all three of the 'edits' variable element types was counted. The rationale for this is that by containing different kinds of edit, texts are more likely to be representative of editing style variation. Twenty-two per cent of texts in the sample were found to meet these criteria, with 82% of these consisting of five or more separate elements. As for replies whose variation primarily represents the insertion of individualised elements, replies consisting of at least one-third individualised text (based on word count) and with no more

than two instances of edit style variable elements, regardless of type, were counted. Twenty-one per cent of the sample replies were found to fit these criteria.

These findings suggest that, while the way that reused and variable text is combined may vary from text to text, there is a tendency that suggests two different kinds of mixed reply: those that tend to represent edited fixed text, and those that tend to represent the insertion of individualised text in between fixed elements. However, many mixed replies may combine the two, and based on the criteria used to identify these different types of mixed reply, over half the texts in the sample did not match either set of criteria. That said, the finding still illustrates a tendency in a substantial number of the replies in the sample to match one of these mixed reply types. These types are illustrated in Figure 7.3, based on texts from the sample.

Mixed reply with edit style variable elements   Mixed reply with inserted individualised element
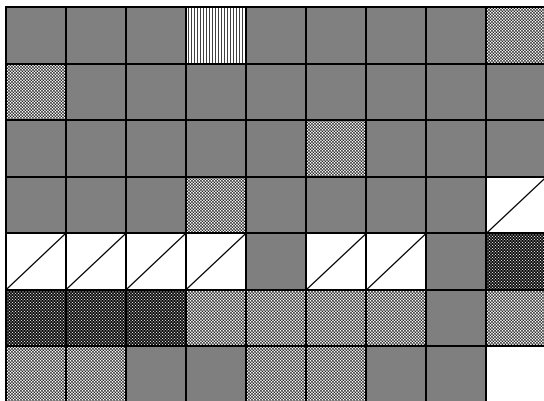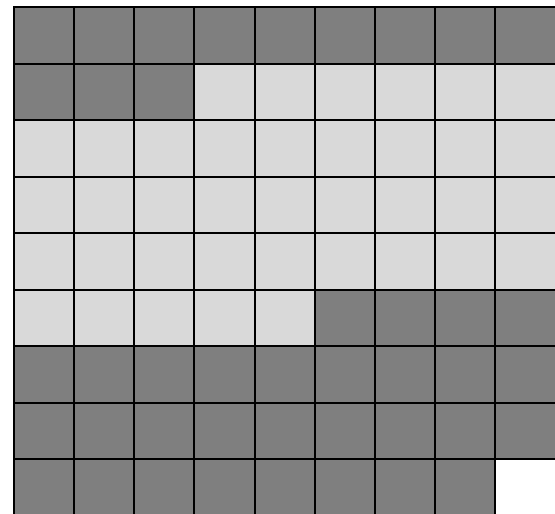
Figure 7.3 Visualisations of two different types of mixed replies

In Figure 7.3, each square corresponds to a word: the dark-grey squares represent fixed elements and the light-grey squares represent individualised elements. The patterned squares represent the other variable element types, which are variable stock (black-dotted), repackaged (diagonal line), expanded/reduced (vertical line) and near-synonym (white-dotted). Figure 7.3 illustrates how these variable element types occur as brief, sporadic edits in the text represented by the visualisation on the left.

7.3.4 Patterns in 100-text sample

This subsection develops the analysis presented in Section 7.3.2 by reporting on patterns in the language of the different elements identified, based on a review of all the replies in the sample. The analysis here will consider each element in turn in the order: fixed, individualised, variable stock, repackaged, expanded/reduced and near-synonym elements.

7.3.4.1 Fixed elements

The review of fixed elements in the sample corroborates the finding from the analysis of the Figure 7.1 example that fixed elements consist of stock politeness routines. Across the sample, there are also numerous examples of language that is the same as or similar to the language of the most frequently repeated boilerplate chunks identified in Section 5.2; for instance, *If you would like to discuss* (TP33), *Thank you for your* (TP1), *We are sorry for* (TP36), *We always endeavour to* (TP35) and *We currently have* (TP33). These are, respectively, representative of offers/requests, thanks, apology, value statements and explanation – formulaic discourse functions of stock replies identified in Chapter 5 on this text type.

However, fixed elements do not always occur in the general and formulaic style characteristic of stock text. For example, the fixed element *You're clearly very unhappy about your experience* (TP20) uses language in a way that suggests the writer is referring to a specific individual comment. The conversational contracted direct address *You're*, combined with the evidential response marker *clearly* (Kang, 2017), creates the effect of the writer responding to something in particular; namely, a particular way that the patient is *very unhappy* rather than the general sense in which this might apply to most negative feedback. The effect of reused text being individually targeted can also be created when staff refer to specific details in comments but in a general enough way that allows the wording in a reply to be used more than once, for example when referring to a common topic that recurs across comments, such as appointment availability: *Thank you for raising your concerns about the availability of appointments* (TP8).

An interesting feature of some fixed elements revealed by the review of the sample is that of representing part of a sentence where the remainder is completed by individualised elements.

This is illustrated by the following from the sample pair TP24 (individualised elements are within brackets); the staff respondent(s) write(s) that they are:

> so pleased that you found our (post operative service so helpful)
> so pleased that you found our (phlebotomy services so good)

This suggests that fixed elements in mixed replies can function as sentence-level frames into which tailored text is inserted, as might be expected with a letter template. However, the occurrence of fixed elements in this way is infrequent in the sample, suggesting mixed replies are more likely the result of ad hoc changes than text deliberately designed to be mixed.

7.3.4.2 Individualised elements

Just as fixed elements can have an individualised style, conversely individualised elements sometimes produce a stock-like effect, as is the case with this next example from TP12:

> It may be helpful to you to know that, as part of their core training, all GPs now are encouraged to explore patients' own ideas, concerns and expectations

A search of the element reveals that it occurs only once in the staff replies corpus, which suggests it is an individualised element where the claim about the benefit of the information being provided is likely based on how the staff member has interpreted the patient's comment. In all other respects, the language used here – a general statement about an institutional process (i.e. staff training) and expression of values (i.e. that staff are encouraged to empathise with patients) – suggests that it is a stock organisational message. The stock-like nature of this example shows that the inclusion of an individualised element in a mixed reply does not automatically represent personalisation.

Impersonal individualised elements can reflect the influence of marketised discourse on the language of respondents to patient feedback, where adding individualised text to reused text is not motivated by patient engagement but self-promotion. Responding to criticism about appointment availability – *I have spent hours on the telephone to try and get appointments for myself, my hubby and my son and its impossible* – the writer of a reply in which the

following individualised element occurs makes a claim contradictory to the patient's reported experience (from TP15):

> We now have one of the lowest patient to doctor ratios in Oldham and as I write we have advance appointments available for Wednesday

The allusion to statistics here is a persuasive technique used to support an argument that refutes the patient's account of their experience. In going to such efforts to promote the brand of their GP practice, the staff member insinuates that the patient has been misleading about their reported struggles to book an appointment. This is likely to have a negative relational effect on the patient, and demonstrates how marketised discourse norms can override the interpersonal functions of staff language use.

A commonality of the two previous examples is that they are explanatory. While these create an impersonal effect, individualised explanatory elements can also involve staff providing information in a way that is likely to be helpful to patients, such as by outlining the procedure for getting help with a particular matter:

> If you contact the surgery on [telephone number] and choose option 4 you will be able to speak to one of the medical secretaries who will be able to help you with your query regarding your referral appointment. (From TP20)

Individualised elements also take the form of recapped details or evaluation, as occurs in a reply pair in the sample (TP30) where one of the texts includes a sentence that recaps the specific negative experience of the patient: *We are sorry you are experiencing difficulty in getting an appointment*. This conveys engagement with the patient's reported experience, but the same acknowledgement is not included in the other reply in the pair, despite the substantial amount of reused text between the replies and the fact that the comments of the replies both primarily represent criticism of the practice's appointment system.

A review of the language of the comments suggests a reason why the recapping apologetic sentence occurs as an individualised element in one text rather than as a fixed element across both. In the comment that receives the individualised element in response, the patient states their evaluation and describes the reason for it: *poor service unable to get appointment and*

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even telephone call has a waiting time of three days. In the other comment, the patient is more scathing in their criticism, listing negative adjectives to dramatic effect: *The appointments system is frankly ridiculous. They could not have devised a more difficult, off-putting, frustrating or useless method of making appointments if they tried*. The omission of the individualised element in reply to the latter comment seems likely to represent the act of withholding personalisation when feedback goes beyond the point of being constructive, as is arguably the case here.

This example of an individualised element demonstrates how recapped evaluation can produce a personalised effect just as well as it can produce an impersonal effect, as observed earlier with the Figure 7.1 example (see Section 7.3.2). It also suggests a way in which staff can engage in subtle relational work, such as by withholding personalisation when a patient's criticism might be judged to be excessive, which may be preferable to staff trying to challenge such criticism.

Challenging perceived unreasonable criticism, even when done in a subtle, indirect way, risks adverse relational effects. This is suggested by an individualised element in TP14 in which a detail from a comment is recapped: *We apologise if you feel a member of staff was rude*. While the intention of the staff respondent might not be to challenge the criticism of the commenter, reframing an absolute claim of the patient – [the] *rude member of staff* – as a subjective experience – *if you feel* – may suggest the staff member is questioning the veracity of the patient's representation. This example illustrates how recapping details from patients' comments entails some form of interpretation, whether witting or unwitting, that risks producing a negative effect on the patient.

Recapping details from patients' comments even in ways that seem innocuous can convey interpretations that potentially produce impersonal effects. For example, in response to a comment in which the writer relays a narrative of their mother's experience of pain, trying and failing to get a doctor's appointment, then going to hospital and discovering she had a blood clot, the staff member sums up this account with the individualised element *your mother's case* (from TP13). Although this individualised element suggests a degree of engagement with the content of the comment, the word *case* in an institutional healthcare context arguably represents a workload to be processed. That the writer did not opt for a less

impersonal choice, such as the word 'experience', may reflect the influence of an institutional register on the language of staff when they communicate with patients.

7.3.4.3 Variable stock elements

Variable stock elements are also similar, in some respects, to fixed and individualised elements: similar to fixed in the sense of often being general and suitable for reuse, and to individualised in the sense that their inclusion or omission can serve particular interpersonal functions. This is illustrated by a relatively long variable stock element in one of the texts of a pair in the sample (TP11) which includes: a request for contact (*Please call the practice to speak to…*); a conciliatory expression (*We … hope that in future you will see an improvement*); information about a *Patient Participation Group* plus an invitation *to join that group*; and a value statement (*[NAME] is committed to making things better*).

The cumulative effect of the components of this variable stock element is of formulaic reassurance. Whether this works to reassure the patient will most likely depend on how they feel about the management style. However, the writer could just as well have included an individualised element to provide more personalised reassurance in response to the patient's negative comment. In the same position in the other reply in the pair they do include an individualised element: explanation of consultation protocol in response to a patient's criticism of not being able to discuss multiple health issues at the same appointment. That the criticism relates to practice procedure means the issue represented in the comment can be readily addressed by an individualised explanatory element.

In the comment for which the variable stock element is used in reply, the content is less amenable to such an element because it includes the following accusation: *The medic smirked at me when I tried to talk about my mental health issues*. To address this using an individualised element might risk expressing acceptance or refutation of a claim that arguably requires a level of careful management not permitted by the context of responding to feedback in a public online space. Therefore, the variable stock element used, one that expresses reassurance and offers several avenues of offline contact, seems appropriate in this exchange.

The interpersonal significance of variable stock elements is not necessarily represented by their inclusion but sometimes instead by their omission from a reply in a pair. For example, the following stock element occurs over 100 times in the staff replies corpus, and as a variable stock element in one of the sample pairs (TP13):

> The practice aims to provide a good level of patient care and ensure patient satisfaction. We are sorry if this has not been the case.

In reviewing original comments to establish why this element occurs in one of the part-identical mixed replies in the pair but not the other, these were found to be very similar: commenters reporting the experience of older relatives, a mother and a grandmother, who were admitted to hospital after trying and failing to see their GP. The stock element seems inappropriate to use in response to both comments as it includes an expression of values that is at odds with the reported experience of patients.

The reason for this element's inclusion in only one of the replies in the pair seems to be based on the content of the original comment that received the reply in which it is omitted. Here, the writer describes how their relative lost consciousness in the surgery and then left without being able to see a doctor: *They sent my grandmother away without asking how she was getting home or letting a nurse check her sugar/blood pressure*. With this, it is possible that the respondent may have felt the practice was culpable for not providing more care, enough for them to omit the stock element that represents them as caring. However, they do not omit it from the other reply. This may be because, in the comment, a lack of care of the GP practice is implied in the way the writer describes the need for their mother to go to hospital because no GP appointments were available. As the experience of the patient in this case was based on procedural and resource factors rather than staff behaviour, the respondent may have felt it appropriate to leave the stock element in.

This example suggests that staff have an awareness of the inappropriateness of the use of stock value statements in some instances. That this does not extend to all instances where the claim of a value statement jars with the reported experience of patients may indicate that the influence of corporate discourse norms – that is, the positive representation of organisational identity – is stronger than interpersonal concerns on the language of the staff member in this example.

The influence of corporate discourse on variable stock elements is not only evident when staff reply to negative feedback; it is also present in responses to positive feedback, the effect of which is likely to be a souring of patients' good feelings. For example, a reply pair (TP7) from the sample includes a text with the variable stock element *Our nurses and healthcare professionals take pride in what they do, as do all staff at the practice*. This general statement about staff values, corporate-like in the way employees at a GP practice are represented as sharing a single consciousness, is the only part of the reply that can be linked to the comment's high praise of nurses. In the comment, the patient describes their fear of giving blood and praises the actions of nurses in helping alleviate this fear, noting that: *not only was I impressed that this was the quickest/easiest time I've had blood taken, I felt that the nurse actually cared for my well being too*.

The respondent's use of a stock element in reply is tantamount to no response to the patient's compliment, which previous research has highlighted can be interpersonally meaningful (Maíz-Arévalo, 2013); here, the absence of staff explicitly acknowledging the details of the patient's personal and positive experience seems likely to produce an impolite effect that conveys disinterest in the patient's well-being.

7.3.4.4 Repackaged elements

Another variable element type identified through the coding of the mixed reply sample pairs are repackaged elements, and a review of the 100-text sample reveals examples that corroborate the finding from the analysis of the Figure 7.1 example (see Section 7.3.2). These include variation, between pairs, in wording that effectively represents repackaging of the same meaning or effect, such as: *do our best* compared to *try our hardest* (TP7); *While this is not the forum to enter in to a discussion* compared to *Although this is not the forum for discussion* (TP15); and *for further details* compared to *for further information* (TP16).

As with the earlier example, the absence of any other reason for the variation suggests repackaged elements represent change for the sake of change, perhaps to avoid the impersonal effect of word-for-word repetition. The nature of repackaged elements as individualising but not personalising text suggests an effort by staff to at least avoid the impersonal effect of copied and pasted replies, as might particularly occur when replies are displayed in close proximity on NHS Choices.

7.3.4.5 Expanded/reduced elements

Repackaged elements represent a variable element type that was classed as an 'edit' in Section 7.3.3. A further example of this kind of variable element type is that which represents words being added to or removed from sentences. As was noted with the example analysed in Section 7.3.2, expanded or reduced wording may represent variation in terms of register, such as is suggested by the added words in the following element (additional words displayed within parentheses): *We offer 'book on the day' appointments and pre-bookable appointments with all our GP's [to our registered patients]* (TP42). In the absence of any specific explanation for their inclusion (e.g. the need for clarification had the patient indicated they were not a registered patient), the added words create an effect of precision, of spelling everything out, as might be associated with an on-the-record official register.

Additional words can sometimes produce a circumlocutionary effect of formal politeness that might be associated with a customer service register, as in the following examples:

> Thank you for [taking the time to post] your comments/your feedback (TP36)
> [Kindly be assured that] we take all comments/suggestions and complaints seriously (TP5)

These examples display variation between text that includes the additional words displayed within parentheses and text that does not. Just as register tendencies are suggested by the additional words, so too are they suggested by the omission of these words which, relatively speaking, are less obviously performative of politeness and more direct.

Additional words of a fixed element that occurs in one text in a sample pair but not the other do not always indicate a choice that can be explained in terms of register, as is illustrated by the following example (from TP33) where the additional words allude to a specific part of the comment:

> We currently have many regular doctors [and staff] working in [NAME] [who have been here many years and some new doctors].

A review of the comment to which this is a reply reveals that the patient is critical of high staff turnover. By adding in a clause of information about staff longevity, the writer subtly refutes the patient's claim. Minor changes to existing text like this are arguably preferable to inserting individualised elements to serve the same function, where a full sentence that makes clear the purpose of refutation more likely risks antagonising the patient.

7.3.4.6 Near-synonym elements

The final variable element type that will be explored in this analysis are near-synonyms; these are different words or combinations of words between texts in a sample pair that occur in the same position and have a similar meaning and function but which produce distinct effects. Examples include variation based on register, similar to that observed with the previous element type. Choices between different registers are represented by variation between conventionalised informal or formal wording such as *Many thanks* and *Thank you* (TP14), and variation between passive and active sentences like *this will be passed* and *I shall pass this* (TP19).

Passive sentences, such as the example here, can create a formal, polite effect as might be associated with an official or professional register. In contrast, active sentences are less mannered and more direct. These are also more personalised in the sense that they can represent an agent acting or feeling a particular way, while passives can entail agent deletion. However, if the use of passives creates a professional-sounding effect, these might be more positively evaluated by patients.

As well as indicating register in terms of degrees of formality, near-synonym variation can indicate register as it relates to a particular discourse, namely a corporate discourse. The following examples illustrate the choice between using language that is more or less corporate: *all my staff* vs *my team* (TP25) and *manager* vs *management team* (TP12). Both examples include options containing the word *team* which arguably creates a corporate effect. This is partly because of the way it can suggest that workers are a group with a single purpose and consciousness – such as *Our … team are always pleased to hear* (TP44) – and partly because of the suggestion that people enthusiastically belong to such a group, just as someone might belong to a sports team.

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A strong meaning association between sports and the word *team* is suggested by collocates of the word as it occurs in the BNC: the top 10 collocates (based on using Dice coefficient) include 'football', 'England' and 'winning'. In this sense, a team represents a competitive group, which is another reason why, in a service context, the word might be regarded as linked to a marketised discourse.

Marketised discourse is also suggested by the self-promotional use of language evident in the following instance of near-synonym variation: *These are the range of appointments we have as we have tried to cater to all out patients needs* and *No patient should wait more than a few days for an appointment* (TP30). Both choices represent value statements about appointment availability, and both are corporate, though in different ways. While the first involves the writer positively representing the efforts of staff (i.e. *we have tried to cater to all*), the second is slogan-like and therefore resonant of the language of advertising.

The review of near-synonym variation in the sample reveals that this often entails a choice between different degrees of personalisation, as is demonstrated by pronominal variation. Choices between different pronouns can function to express deictic closeness or distance (Charteris-Black and Seale, 2010), which is suggested by examples of near-synonym variation between reply pairs in the sample; for example, variation between the third-person *the practice* and plural first-person *we* (TP39), where the first refers to an 'other' and therefore conveys more distance than the second which refers to a 'self', albeit a collective one.

Another example is variation between the plural first-person *We are* and singular first-person *I am* (TP24), where the latter conveys more relational closeness than the former because it represents an individual self, someone who is potentially more knowable than the referents of ambiguous *we*. To some extent, personalisation is linguistically encoded when it comes to pronominal choices, though contextual factors may also influence their effect on patients. For example, the rationale for the plural first-person expressing greater relational closeness than the third-person may not apply if the patient interprets the use of 'we' as being impersonally corporate-like or as the royal 'we' which can produce a distancing effect.

Other patterns of near-synonym variation involving a more personalised choice include variation between patient- and institution-focused representations, and variation between

wording that is more or less expressive. Examples of the former are as follows: *hearing from you* and *receiving these* (TP5); and *for letting us know of your concerns* and *for your comments* (TP2). The first options in these pairs include direct reference to the addressed patient via the second-person *you* and reference to the patient's experience (*your concerns*). The second options include references to information for institutional processing purposes: *these*, referring anaphorically to the commenter's contact details which the respondent has requested, and *your comments*, which foregrounds the means over the meaning of the feedback provided, focusing more on the message than what this represents in terms of patient experience.

Near-synonym variation between wording that is more or less expressive is illustrated by the example pairs *lovely* and *positive* (TP18), as in *Thank you ever so much for your lovely comments* and *Thank you ever so much for your positive comments*; and *such a poor* and *a negative* (TP32), as in *I am sorry you have had a negative experience* and *I am sorry … you have had such a poor experience*. In the first pair, both words represent an evaluation of the comment, but the word *lovely* also conveys the emotional response of the writer while the word *positive* is a general evaluative category. The word *negative* in the second example also fits this description, while the intensifier *such a* combined with the vivid word choice *poor* represents an expressive use of language that is more likely to engage the reader.

The examples of variation between near-synonyms in the sample considered above highlight choices that tend to be based on either interpersonal functions or the influence of a corporate discourse, though it is worth noting that the interpersonal choices might represent a more subtle way in which staff are being corporate. While obviously corporate-style language might be characterised as impersonal, the effect it has on individual patients may depend on their expectations about what constitutes appropriate language use in the context of healthcare staff responding to patients' online comments. With regards to choices identified as representing personalised language use, in many instances these relate to more general interpersonal norms where their effect is less likely to vary depending on the individual patient. For example, a singular first-person pronoun is probably always likely to create more of a personal effect than a third-person pronoun where these represent viable alternative choices.

7.3.5 Summary of variation analysis

This section has demonstrated the variety of ways that fixed and variable elements combine to produce mixed replies. Two main kinds of variable element have been identified: those that suggest wording has been edited and those that suggest the insertion or removal of information that is often tailored to individual comments. Different types of variable element within these two groups can occur in various combinations with reused text. While the tendency for mixed replies to sometimes contain more individualised insertions and fewer edits, as well as vice versa, was observed in Section 7.3.3, on the whole, how variable elements combine with fixed elements is quite idiosyncratic. Given this and the relatively small size of the sample, no quantitative patterns have been identified that might be used to characterise the practice of combining elements at a text level.

However, by identifying different types of variable element and analysing language use in relation to these, this section has provided an account of the mechanics of mixed replies. This has involved highlighting text editing choices of staff which demonstrate how staff engage with relational work at a micro level of language use. The variety of often very subtle ways that replies can be personalised, as revealed by the analysis, demonstrates the practice of balancing text reuse (e.g. for management purposes such as to save time and to reproduce consistent functions or messages) with modifying text to make it more engaging. This seems to work more effectively in some cases than others.

Text editing choices highlighted in this section also reflect the influence of marketised discourse on the language of staff respondents to feedback. As many of the examples of this produce an impersonal effect, the influence of this particular discourse can be viewed as being at odds with the relational purposes suggested by personalised choices. In this way, a main finding of the above analysis of mixed replies is that their use reveals tensions between interpersonal functions and marketised discourse norms in the language of staff replies.

7.4 Conclusion

The expectation for mixed replies to represent a balance between unique and stock replies is partly confirmed by the findings presented in this chapter. The qualitative analysis of samples in the previous section has illustrated ways that mixed replies include both reused stock text

and individualised elements, and, therefore, the time-saving and personalising benefits associated with each. However, this also means they can include features of these other two reply types that may produce impersonal effects; for example, formulaic language that might be evaluated negatively as mechanical, or references to specific details in feedback that contradict claims made by patients. In this way, while mixed replies can represent a balance, this often does not take the form of an ideal balance between efficiency and personalisation.

The individualised elements identified in mixed replies include examples of tailored details that may be helpful to patients, such as explanations of procedures specific to an individual patient's needs. More typically, individualised elements were found to include very subtle or informational references unlikely to produce a noticeably personalised effect. Furthermore, the findings in this chapter have highlighted how the majority of the non-reused text in mixed replies does not, in fact, represent individualised elements, but other kinds of text such as edits to slightly change the wording of stock text. Therefore, mixed replies might often be more accurately characterised as edited stock replies rather than an evenly balanced composite of stock and unique, meaning that many of the observations made about the language of stock replies in Chapter 5 are likely to also be applicable to this reply type.

The tendency for the non-reused elements of mixed replies to represent slightly edited wording, as highlighted by the variation analysis in this chapter, suggests a resistance among staff to full verbatim text reuse, but not to the non-personalised stock replies that can remain after such edits. This raises a question as to whether the time spent individualising the text of replies in this way might not be better spent personalising the content of replies. An efficient means of doing this might be to reflect details of feedback by recapping specific words used by the authors of that feedback, as suggested by several mixed reply keywords that show some staff already engage in this practice.

The analysis of mixed replies has highlighted a number of features that represent potentially useful resources for staff when responding to feedback. These include the feature described in this chapter as non-specific individualisation, which refers to language that is midway between general and specific, and might be used in a series of stock replies slightly tailored to different kinds of feedback. They also include the practice of withholding personalisation, which might be employed when staff are producing mixed replies in response to rude or unfairly critical feedback; rather than react similarly in response, as was sometimes found to

occur with unique replies, an exercise in protest while preserving the face of both parties might be for staff to withhold the personalisation they might otherwise have included in their reply.

As with the other reply types, evidence of marketised discourse was also found in the analysis of mixed replies, as occurs when staff selectively recap patients' praise for purposes of self-promotion. Such discourse has negative implications for the patient-centred care purpose of staff replies, a point that will be reflected on in the next chapter, which is the conclusion to this thesis.

Chapter 8: Conclusion

8.1 Introduction

This chapter presents the conclusion to my thesis. The first section after this introduction (Section 8.2) reflects on the findings from the thesis with a discussion on notable themes and issues that are representative of all types of staff reply examined in this study. Then, Section 8.3 summarises the different ways that my research contributes to the literature, both in terms of what it adds to existing knowledge and the gaps it fills between the limits of previous research.

This is followed by Section 8.4 on 'Impact'. This section is divided into two subsections: Section 8.4.1 presents an argument for how the findings in this thesis can have implications for practice, and Section 8.4.2 presents recommendations to healthcare staff on how to personalise responses to patient feedback. Section 8.5 then describes previous and future dissemination activities for this PhD research.

This is followed by Section 8.6 which identifies the limitations of the thesis and opportunities for possible future research. Finally, the chapter concludes in Section 8.7, which provides some general reflections on the study as a whole.

8.2 Reflections on findings

In this section, I present a reflection on the findings from my PhD project, specifically with respect to how these address the thesis research questions. The section will consider each research question in turn, and centres primarily around the two (RQ2 and RQ3) that constitute the main focus of the study.

The first research question in this thesis (*What factors, such as type of feedback (whether positive or negative) and provider type, influence different uses of language?*) is primarily addressed by the quantitative results reported in Chapter 4. These include the main finding – for the three service areas considered (GP practices, Dentists and Hospitals) – of an increased likelihood that staff will produce unique replies when feedback is negative (see Table 4.3 in Chapter 4). The reason for this is that negative feedback is more likely to warrant an

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individualised response to explain the situation that is the object of a patient's complaint. This is confirmed by keyword findings in Chapter 6, which reveal that explanatory language is characteristic of unique replies. Negative feedback is also sometimes likely to provoke a more individualised response to defend against criticism, as suggested by the retaliatory nature of some staff language use that is implicitly critical of patients, such as via the use of sarcasm (an example of this is included in discussion relating to RQ2 below).

An expectation that positive feedback would receive more stock replies, based on the notion that praise might be sufficiently reflected by a general expression of appreciation, was partly confirmed by the finding that GP practice staff were more likely to use stock replies to positive feedback. Few other differences in language use determined by provider type were found in this study, other than those that are topic-specific (e.g. words relating to hospital departments – see Section 7.2). On the whole, then, with the exception of negative feedback, the influence of feedback and provider types on how staff use language was found to be limited.

A large proportion of the findings presented in this thesis addresses the two research questions (RQ2 and RQ3) that will be considered next. This includes evidence of how use of language in replies to online patient feedback imply a number of roles and identities for staff and patients, which addresses the second research question of the thesis: *How do linguistic choices position staff, patients and the relationship between them, and how does this relate to the concept of patient-centred care?* The most typical identity of staff implied by the language used in replies is that they are organisational actors. This is implied by the high amount of reused text in staff replies – an attribute of stock and mixed replies (which comprises two-thirds of the texts analysed in this thesis) – that serves the NHS organisational purpose of efficiently and consistently responding to feedback.

The language used in replies positions staff as organisational actors in several ways; for example, as mouthpieces of the organisations they represent, such as when staff make value statements (one of the most frequent 'discourse functions' in stock replies; see Section 5.2). Many of these value statements produce the impersonal effect of staff parroting a prescribed official message in a way that implies a vague general audience, as in the example: *We value all comments from patients and their families* (in 95 texts). That staff broadcast such general

messages in stock replies rather than reply to feedback individually arguably undermines the value claims being made.

Another way staff position themselves, when in the role of organisational actors, is by adopting a more personalised style of language in stock text intended for reuse, different to that which creates the effect of staff being organisational mouthpieces. This is demonstrated by the finding that reused elements with the same discourse function can be more or less impersonal. For example, two boilerplate chunks (i.e. repeated word sequences; see Section 5.2) that are among the most frequent in stock replies are *we appreciate your* (occurs 65 times) and *we are delighted* (occurs 69 times). Both convey appreciation for feedback, though the second is more effusive than the first and has an expressive style (based on use of the strong emotion word *delighted*) that helps create a personalised effect.

The extent to which style can personalise stock replies is limited by the impersonal nature of reusing text. Stock replies are a one-size-fits-many way of responding to feedback where multiple patients and their experiences are treated the same, and in this way, they arguably represent the antithesis of patient-centred care. While there may be an argument for using stock text when the same kind of issues recur in patient feedback, therefore meriting standardised responses, in practice repeatedly copying and pasting the same reply seems to occur indiscriminately. This is particularly illustrated when stock replies mismatch patient feedback, suggesting staff have not even read feedback, such as when a stock apologetic reply is used to respond to positive feedback (see Section 5.5).

In addition to being organisational actors, staff are individuals with distinct personalities and feelings, and the linguistic choices they make often position them as such, especially when producing unique replies. The personal feelings or attitudes of staff, distinguishable from how they might be expected to express themselves as organisational representatives (i.e. in an on-the-record, polite, professional manner), are often conveyed indirectly in replies. This is demonstrated in Section 6.3 by the analysis of the unique replies keyword *unfortunately*, which highlights instances of staff using sarcasm to express feelings of frustration about the unreasonable nature of some feedback (*we are … unfortunately unable to control how steep Thorncliffe Road is*). Another feature of unique replies that conveys staff feelings is the use of distancing strategies, revealed in Section 6.4 to be a common function (38% of the time) of staff use of third-person address forms. This is illustrated by the example, *I can not comment*

on an assumed telephone conversation this person thinks she overheard, which implies feelings of suspicion about the veracity of claims made by a patient in their feedback.

As suggested by these examples, the linguistic choices of staff can sometimes position patients as troublemakers, an idea also associated with the practice of patients leaving feedback anonymously. In a review of the concordances of *unfortunately* collocating with *anonymous* (see Section 6.3), every instance (17 in total) entails staff identifying anonymity as either a reason not to address feedback, or an object of criticism; for example, *Unfortunately, anonymous comments on sites such as this are not constructive*. The insinuation that patients have done something wrong suggests a lack of empathy with possible motives behind anonymity, such as fear that criticising staff will negatively affect commenters' healthcare.

Another interpretation is that, rather than reflecting a lack of empathy, this kind of response represents a deliberate strategy to invalidate criticism by framing patients as having acted in error. By using anonymity as a reason not to address feedback, and therefore ignoring NHS Choices' own advice to treat anonymous and named feedback the same (see Section 3.3), staff are revealed to sometimes act as gatekeepers deciding which feedback to treat as legitimate.

While some findings from the analysis of unique replies reveal a variety of ways staff use language to convey their feelings about feedback, other findings represent staff performing an administrative role. Explanation-indicating keywords and those relating to the theme of appointments (a typical object of explanation) highlight the practice of staff providing information to address issues raised in feedback. For example, *48 hours* – a compound of the keyword *hours* and its strongest collocate *48*, occurring 261 times in unique replies – is almost always used by staff to provide information about institutional procedures. With about half of the unique replies keywords identified linked to this function, the positioning of staff as organisational actors, identifiable with the language of replies containing reused text, is also a major characteristic of one-time-use replies.

Despite the positioning of staff as organisational actors being most commonplace in replies to feedback, patterns of language use that convey the individual feelings or attitudes of staff have been given considerable attention in this thesis, primarily in the analysis of unique

replies (Chapter 6). One reason for this, as examples above show, is that such patterns have tended to reveal an adversarial stance towards patients. This is salient because it runs contrary to expectations about the patient engagement purpose of a feedback mechanism like NHS Choices.

That staff tend to adopt such a stance can be explained by the influence of staff and patients interacting in a public online space, where each party may feel the need to position themselves relative to a public audience, as well as each other. This is illustrated by the example of sarcasm above (about not being able to control the steepness of the road), which expresses exasperation with feedback, and therefore also a likely face threat of the author, but in a humorous style seemingly intended for the benefit of an imagined public reader. In this respect, the public online context of the language use examined in this thesis suggests the inherently impersonal nature of staff responding to patient feedback on NHS Choices, and helps explain the limited evidence of patient-centred care found in this study.

In addition to findings about how language use implies different relational positions between staff and patients, this study has highlighted evidence of a number of discourses in staff replies, which addresses the third research question: *How does staff use of language reflect different discourses in terms of (a) register and (b) ways of viewing the world, and how do these relate to patient-centred care?*

Several registers have been identified in this thesis, the most widely adopted being a managerial register, which relates to the same language used to position staff as organisational actors. A managerial register refers to the use of formulaic, task-oriented language and representations of institutional procedures that perform the function of managing contact with patients when they post feedback. This register is characteristic of stock replies which, as shown in Chapter 5, often consist of boilerplate chunks that occur similarly across multiple texts and serve a limited number of functions. For example, 'Offer or request' boilerplate chunks – such as *If you would like*, *Please can I ask*, *Please feel free to*, *I would very much*[11] – typically serve the management function of bringing texts to a close

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[11] Examples from 11 'offer or request' boilerplate chunks identified. These occurred in 442 different texts (3,467 when counting duplicates).

in a polite manner with a message about continued service availability (i.e. an offer or request for further contact).

A managerial register has also been found to be a common feature of mixed replies, because these are often based on stock replies, and unique replies, where explanation-indicating keywords reveal the managerial register feature of procedural information representation (see the *48 hours* example above in regards to positioning). The strong presence of this register across replies can be attributed to the fact that these texts are likely to have been produced by managers or other administrative staff.

However, while a managerial register is generally used in replies containing reused text (i.e. stock and mixed replies), distinctly different registers were found to occur in unique replies; for example, a formal politeness register and informal conversational register, with the former illustrated by use of the dummy pronoun *it* (a collocate of the keyword *is*) in expressions like *it is regrettable*; and the latter by *sounds like* (105 times) and *only just* (83 times), phrases identified via an analysis of keywords and found (in the BNC) to be more characteristic of spoken language use.

With respect to the question of how this relates to patient-centred care, such variation shows that staff have a choice of registers when they produce individually written replies for one-time use. This suggests the possibility that one register may be preferable to another for the purpose of engaging patients. However, evaluating registers in terms of how they are likely to function interpersonally is problematic. A formal, official-sounding register might produce the effect of professionalism and trustworthiness in contrast to an informal, conversational register which could be perceived as unprofessional. Contrarily, the more formal register may seem detached and uncaring compared to one based on familiar everyday talk. In this way, the question of which register is most suitable for responding to patient feedback does not have a straightforward answer.

One possible interpersonal use of register is for staff to reflect that adopted by individual patients in their feedback (in line with accommodation theory; see Sections 2.4.1 and 5.5). However, such accommodation may be ineffective if patients' positive evaluation of register were to be based on how they expect staff to be behave; for example, if they expect staff to behave as customer service providers. Indeed, this seems to be an expectation of staff

members themselves when they use language associated with a managerial register that might also be interpreted as a customer service register. A main feature of such a register is emphatic politeness, an effect often created in stock replies when different discourse functions, all expressing appreciation, occur in combination; for example, 'Thanks', 'Affective expression' (e.g. *I am so pleased that you had a positive experience*) and 'Reported action' (e.g. *The teams involved will be delighted to read your feedback*). Other features include the brand-like effect of staff sharing common service values, as occurs with value statements (mentioned above) and self-promotional language, a number of examples of which have been identified throughout this thesis.

Another meaning of discourse is that which refers to a particular way of looking at the world. A discourse in this sense of the word that has been especially prevalent in staff replies is one that shares many of the same linguistic features that mark a customer service register, namely a marketised discourse. This refers to a way of viewing the world that is shaped by the values and norms of business and enterprise, and is particularly salient in the context of NHS healthcare where such values and norms are arguably in conflict with a tax-funded universal healthcare system. In this respect, marketised discourse in an NHS context may warrant a systematic critical analysis. While such an approach has not been used in this thesis, critical observations have been made where the influence of a marketised discourse is evidently at odds with the NHS principle of patient-centred care.

For example, mixed reply keywords, such as *impressed* and *five (stars)*, highlight the practice of staff selectively recapping praise in feedback instead of details of patients' reported experiences (see Section 7.2). In mixed replies, which have limited space for individualisation, this selectivity shows that, given the choice between self-promotion and patient engagement, staff often favour the former. Evidence like this demonstrates that, with marketised discourse, self-interest is ultimately prioritised over patient interest. This highlights the need for caution when entertaining potential arguments in support of marketisation, such as the idea that consumer choice will help empower patients.

In this thesis, evidence of a marketised discourse has been noted across the different reply types and as occurring in a variety of forms. A counter-discourse to marketisation is arguably collectivisation, a way of looking at the world that promotes collective responsibility such as the kind exemplified by universal healthcare, as provided by the NHS in the UK. In contrast,

market-based values, as tend to be associated with neoliberalism, promote individual responsibility and involve providing choice based on people's ability to pay for it. While some traces of a collectivised discourse are evident in staff replies, as identified in Section 6.4 in the analysis of the keyword *demand*, this discourse seems conspicuous by its absence from most replies. An example of where such a discourse might be expected is when staff are responding to criticism relating to waiting times or appointment availability. Here, a fair response representing the reality of the NHS might be one that identifies how finite resources subject to government budgets are always likely to be a factor affecting service quality in a publicly funded healthcare system.

The final research question addressed by this study – *How can corpus-assisted discourse analysis be used on data consisting of a large amount of reused text?* – is a methodological one that arose from the discovery that staff often reuse text when responding to online patient feedback. The approach used in this thesis for analysing a corpus consisting of substantial text reuse involved dividing the corpus into datasets consisting of text types based on different degrees of text reuse. The details of this method, and therefore a comprehensive answer to RQ4, are presented in Chapter 3. These include the rationale for splitting staff replies into separate datasets to analyse, rather than filtering out and discarding duplicate text: that is, text reuse represents a discursive practice that affects how staff use language. This has been confirmed by the separate analysis of stock, unique and mixed replies in this thesis, the findings from which have highlighted distinct ways staff use language when they produce these different reply types.

8.3 Contribution to knowledge

The research presented in this thesis contributes original findings to knowledge about healthcare discourse in a number of ways. Most notably, given the PhD topic, it contributes new knowledge about the kind of language healthcare staff use when responding to online patient feedback, and the contextual factors influencing how they use language. No previous linguistics research was found to have looked at the topic of staff replies to online patient feedback, and therefore this thesis fills a gap in the literature. As reviewed in Section 2.3.2, several non-linguistic studies have focused on this topic (Baines et al., 2018; Ramsey et al., 2019; Locock et al., 2020), but these have a number of shortcomings, which have been addressed by the approach that I have used in my study.

For example, by using thematic and content analysis approaches, these studies rely on the assumption that the meaning and function of texts can be intuitively known through the act of reading. However, meaning in staff replies can be determined in a variety of ways, such as by how words tend to co-occur with other words, how they are positioned in grammatical relation to each other and contextual factors, such as knowledge of cultural norms and speaker intentions that allow meaning to be expressed indirectly. In this way, to understand what healthcare staff are doing when they produce replies to feedback, a systematic analysis of language rooted in sound linguistic theory is required, and this is what I hope to have provided in my thesis.

Previous research, as represented by the studies cited above, also has a fairly narrow focus that treats staff replies as objects to be classified into text types or to be appraised in terms of quality, but without engaging with broader issues relating to the practice of responding to patient feedback. The focus on different kinds of discourse in the present study, on the other hand (i.e. discourse as register and discourse as ways of viewing the world), has meant more links can be made between the language of staff replies and particular social and discursive norms and practices; for example, those represented by the notion of marketised discourse which has been repeatedly identified throughout this study. Consideration of these wider issues linked to how staff reply to patient feedback is important for reflecting on its purpose, whether it achieves this purpose and if it is a worthwhile thing to do.

This thesis also provides new insights into non-clinical healthcare communication more generally, specifically with respect to how staff interact with patients. Literature on non-clinical communication often tends to view communication as a soft skill, although – as noted in Chapter 2 – more recent work has employed greater social scientific rigour by using conversation analysis techniques. However, there is a gap in the literature of discourse studies on register in non-clinical interactions between healthcare staff and patients. This contrasts with the ample research on interactions in clinical contexts, typically consultations, where negotiating between social and medical registers has understandably been a focus of interest.

The notable finding about healthcare registers in non-clinical settings is that they do not reflect the same kind of consistent and coherent communicative and relational purpose as has been found with registers in clinical settings. For example, in clinical contexts small talk is typically used to support medical talk to help clinicians build rapport with patients. In non-

clinical contexts, as this thesis has discovered, even in a restrictive communicative situation such as responding to online feedback, a variety of registers are used and these reflect different – and sometimes even opposed – purposes (see Section 8.2 for examples). This highlights the lack of an NHS-wide organisational strategy for non-clinical communication, at least with respect to responding to feedback. While there are guidelines, those provided by NHS Choices (see Section 3.3), these are short and general and, based on the evidence in this thesis, not applied consistently across different practices. Therefore, a strategy is arguably still needed, and a case for one is made in Section 8.4 (on 'Impact') below.

Linked to the findings on non-clinical registers is the contribution this thesis makes to knowledge about the interpersonal effects and functions of healthcare discourse. This represents an original contribution in that it reveals how the relational aspects of the language used by healthcare staff are ubiquitous. Unlike previous studies that have focused on how interpersonal routines help clinicians to achieve particular interactional goals, the present study has used a corpus-assisted approach to consider evidence of the relational effects of staff language use in a more general way. This has helped to reveal how healthcare staff engage in relational work at a number of discursive levels when communicating with patients. For example, in addition to using a variety of politeness and impoliteness strategies, staff were also found to often adopt a more or less personalised style, as highlighted by variation between sentences and texts that otherwise share the same meaning and function.

This thesis also contributes new findings to research on the marketisation of healthcare discourse, a topic that has received relatively little attention in the discourse studies literature. When it has been previously studied, the focus has tended to be on broadcast-type texts such as those from health awareness campaigns or the fixed content on NHS websites. However, to the best of my knowledge, no previous research has examined discourse marketisation in relation to the language of staff members when they interact with patients.

This omission means that the findings from this thesis address a gap in the knowledge about the ways and extent to which commercial discourse norms influence the language use of healthcare staff. From a critical discourse perspective, this research represents an important contribution to the literature as it suggests how the problems associated with NHS marketisation may be more pervasive in the discourse.

Another topic area to which this research contributes new findings is politeness. This includes with respect to showing the value of using a discourse approach which addresses politeness as part of a broader view of relational work. This is illustrated by use of the unique replies keyword *unfortunately* in replies that inform commenters about staff members' inability to respond to anonymous feedback (e.g. *Unfortunately we are unable to respond to anonymised comments*). Using a model that treats politeness as mitigation of a face-threatening act (FTA) would likely involve *unfortunately* here being analysed as a politeness term. However, using a discourse approach, as has been done in this thesis, allows for a variety of contextual factors influencing the interpretation of this usage to be considered; for example, the high number of instances where staff do respond to anonymous feedback, the fact that the NHS guidelines advise that anonymous comments should be treated the same as named ones and the potential motives staff may have for not wanting to respond to feedback, such as a lack of time or a disinclination in the face of strong criticism. Factors such as these arguably contribute to an impolite effect of *unfortunately* which, as noted in Section 6.2, is suggestive of unaccommodating officiousness.

In this thesis, *unfortunately* was sometimes found to be used in a manner that could be interpreted as patronising, where the surface expression of regret as a politeness form mismatched the suggested indirect expression of triumph at patients having not followed the correct procedure. This example adds to existing knowledge on mock politeness that might be classified as patronising or condescending language use, such as that which entails an 'attack on sociality rights' as might be found with intergenerational communication or sexist language (Taylor, 2015, p. 132). Whereas Taylor explains previous examples of this kind of mock politeness as the result of 'social stereotypes rather than the accomplishment of local, interpersonal impoliteness goals' (2015, p. 132), the apparent intentional mock-polite use of *unfortunately* in staff replies suggests it can be analysed as the latter.

In addition to producing original findings, this thesis has also identified the new concept of 'synthetic impersonalisation', which refers to when synthetic personalisation features do not represent a local interpersonal choice but reflect the adoption of an impersonal register. For example, representatives of companies often refer to their companies using *we*, rather than third-person pronouns, as this helps create a personalised effect.

However, when plural first-person pronouns are similarly used in other contexts to refer to abstract organisational entities, it can produce an impersonal effect opposite to that intended. This is the case when a corporate register is adopted in staff replies to patient feedback, and *we* is used in this way, which creates the impersonal effect of a staff member representing themselves as an organisation rather than an individual engaged in a one-on-one exchange with a patient. An example of this was provided in Section 5.5 which highlighted a mismatch of registers between staff and patient. In reply to a personal experience narrative in which the patient relays the story of their positive hospital visit, the respondent states: *We appreciate all feedback we receive, as it helps us to continually improve our services*. The organisational message indicates this is corporate-*we*, and while the use of a plural first-person pronoun may have personalised this message in a broadcast for a general audience, when directed at an individual it produces an impersonal effect.

Finally, my thesis fills a gap in the literature by presenting a corpus-assisted discourse studies (CADS) approach for analysing discourse in a corpus that contains a large amount of text reuse. The nearest previous research to this is a paper that identifies text types for the purpose of evaluating text reuse detection software (Sharjeel, Nawab and Rayson, 2017; see Section 2.6). However, in this previous study, the source of the reused text is known and there is no discourse analysis carried out. My thesis represents an original contribution by showing how text reuse needs to be identified, a corpus divided based on degrees of reuse between texts, text reuse conceptualised as discourse and suitable analytic methods employed on the new subsets of data. On this last point, when those methods are a keyword analysis, this thesis has highlighted that the choice of statistical measure may depend on the nature of a corpus (e.g. whether it contains reused text or not – see Section 3.6). In this way, choosing a statistical measure may not simply be a matter of deciding which is best and should always, therefore, be used.

In previous research, corpus studies of duplicates have tended to approach this issue with a view to identifying duplicates for the purpose of removing them, or as part of authorship detection in forensic corpus linguistics. However, as my thesis shows, I have viewed duplicates as important in an altogether different way. This represents a worthwhile contribution to knowledge in that text reuse is likely to become an increasingly significant issue for CADS, especially given the dominance of text-based online communication and the increasing practice of using prepopulated text in online interactions.

8.4 Impact

8.4.1 Implications for practice

The findings in this thesis are potentially useful for helping to improve the way in which some staff respond to patient feedback. They provide examples of 'good' and 'bad' replies where the purpose of responses to feedback is to produce effects that are likely to make patients feel cared for and listened to. These effects can be achieved through personalisation, both in terms of style and content, but they can also be thwarted by impersonal tendencies, as this thesis often found to be the case.

The importance of making patients feel cared for and listened to is that it helps to build and maintain a good rapport between staff and patients. This can be beneficial in terms of patients' general sense of well-being, but it can also potentially have clinical implications if it means that patients are not discouraged from seeing a doctor when they need to and that they are more willing to engage in self-disclosure and adherence to medical advice.

For my thesis to have an impact on practice, NHS managers would need to incorporate the findings into staff training. This could be encouraged through dissemination practices and direct contact with the NHS (see Section 8.5 below) that explains the value of my findings, as described above, to practitioners. However, the success of this proposed impact would depend on how effectively an argument can be made to overcome certain likely attitudinal obstacles. These include the views that responding to feedback is a soft skills issue and can therefore be improved by advising staff to be friendlier, and that concerns about making wording in replies to feedback less impersonal are low on the list of priorities for under-resourced NHS staff.

The first of these views can be addressed by highlighting the fact that the impersonal effects of the language of staff replies are often caused by underlying discourse norms and practices, and not by a temporary attitude of staff members. This is demonstrated in the thesis by the finding that the influence of corporate discourse on the language of healthcare staff results in a high occurrence of impersonal, organisational value statements in staff replies. If staff believe that responses to feedback should be more personalised, then addressing this systemic

issue (i.e. corporate-like practices in the NHS) arguably requires a systematic approach – one that might take the form of discourse-based communications training.

The second proposed view that might hinder the impact of this thesis on practice, namely the view that the wording of replies is low priority, can be addressed by highlighting striking examples of the kind of replies that are particularly likely to produce adverse relational effects. These include replies that completely mismatch, as was found to sometimes occur with copied and pasted stock replies. They also include replies containing face-threatening language (*I can not comment on an assumed telephone conversation this person thinks she overheard*), which insinuates the patient is lying. The potentially alienating effect of such replies may help to convince NHS managers that the use of my findings in staff training is a priority when language is being used in this way.

The argument for training concerns not only improving how staff reply to feedback, but also changing attitudes so that responding to patient feedback can begin to be viewed as a valuable space for staff to engage with patients. That a high number of patient comments on NHS Choices receive either no response or a short, cursory reply suggests the attitude that replies are a courtesy rather than an opportunity for staff to build and maintain good relations with patients. If staff were given the time and training to carry out relational work through their use of language in replies to online feedback, then this would arguably help support good relations in face-to-face interactions between staff and patients, which might also bring the potential clinical benefits referenced at the start of this section.

Having made the argument for why staff should engage with the findings in this study, the next section will provide more practical recommendations about how to use language when responding to patient feedback.

8.4.2 Recommendations

The purpose of this subsection is to propose ways in which staff might personalise their language use in replies to online patient feedback. Recommendations about personalisation techniques included here are intended to help staff improve how they respond to feedback when the primary aim is to create an effect that makes patients feel cared for and listened to.

This is to support the wider aim of promoting good relations between healthcare staff and patients.

The role of discourse in the following recommendations is to mediate between the caring intentions of staff and the care experiences of patients, although it does not constitute the feelings or attitudes of either party. Therefore, a caveat needs to be added to these recommendations, which is that they are intended to support but not substitute the caring intentions of staff. If discourse is used to create a caring effect in a way that is not matched by how staff behave in practice, this is ultimately likely to have a negative impact on staff–patient relationships.

The recommended ideal way for staff to respond to patient feedback is to produce individually written replies for each item of feedback. This would allow staff to address specific issues in the feedback and to offer tailored explanations and advice. It would also free up staff respondents tonally and stylistically, and potentially enable them to converge on the tone and style used by patients in their comments. Based on accommodation theory (see Chapter 2), an effect of this might be to express social solidarity and relational closeness. However, as examples identified in this thesis have illustrated, individually written replies also have a higher risk of producing impersonal effects as they give staff greater scope to express their feelings, even if this comes across unintentionally as indirect impoliteness, which can occur when staff are confronted with strong criticism.

One way to mitigate the risks of individually writing replies is to use templates that combine reusable standard text with modifiable general text, where the latter can be tailored to address the specific details of individual feedback. This would permit informational personalisation but the reused elements would place constraints on the kind of stylistic and tonal personalisation that is possible with individually written replies. Overall, the standard text part of the template would help to determine the kind of register used and control the style and tone of replies, while also providing a time-saving measure.

Another type of reply previously used by healthcare staff to respond to feedback (as identified in this thesis) is the stock reply. This typically entails staff copying and pasting the same reply multiple times and is therefore, by definition, non-personalised. While the use of stock replies is generally not recommended, especially when feedback is negative and may

require staff to address specific raised issues, there are ways in which the general style of language can be personalised. Therefore, if staff do choose to produce stock replies, then it is recommended that they employ measures that help to personalise general language in replies to feedback.

A list of recommendations for how to personalise the style of replies to feedback is provided below. This list is preceded by two mocked-up examples of stock replies to imagined positive comments. These examples represent stock replies for the purpose of illustrating general personalisation measures, but they are recommended for use in any reply type.

The two examples are based on actual examples identified in this study: the first represents a style that is likely to produce impersonal effects, and the second represents a style that is likely to produce more personalised effects. The examples are referenced in the list of recommendations that follows for illustrative purposes.

<u>Reply example 1 – unrecommended 'impersonal style'</u>

Thank you for your comments (1). At [practice name] we pride ourselves in being a leader in customer care (2). It is the ethos of this practice to welcome feedback, as we are continuously striving to ensure a high quality of service for our patients (3). We recognise that there are always areas for improvement, and continue to review opportunities to make changes as required (4). Where necessary new procedures will be initiated (5). Patients can help us with this by joining our Patient Participation Group (PPG) (6). The PPG meets on a 3-monthly basis to discuss a wide range of issues and ways to improve the service for our patients (7). Please contact [contact name] on [contact number] for details (8). We are pleased your experience was positive and will pass on your comments to all parties concerned (9).

<u>Reply example 2 – recommended 'personalised style'</u>

Thank you for your kind and helpful feedback (10). My colleagues and I were happy to hear that you were well looked after and had a good experience when visiting the practice the other day (11). It is a pleasure to read about positive experiences such as yours, and it helps us to know when we get things right as much as when we sometimes get things wrong (12). I

hope you'll use the website again to keep us posted about any future experiences you may have at [name of practice] (13). If you would like to use your experiences to help us improve the practice, you are very welcome to join our Patient Participation Group (here's a link to more information about the group and contact details on our own website [website link]) (14). For now, though, thank you again and I'll be sure to share your lovely comments with the rest of the staff here at the practice (15). With thanks and best wishes, [author's name and position] (16).

List of recommendations

- Avoid the use of vague, abstract wording. Examples like *ethos* and *striving to ensure* (3) suggest a corporate register where the wording seems intended to convey confidence, but in the context of one-to-one healthcare interactions represents language being used for effect rather than to engage with patients. Wording such as *areas for improvement … make changes as required* (4), and *all parties concerned* (9), suggests a detached, official style which could create an evasive effect and, therefore, an untrustworthy impression of healthcare staff.

- Use caring and empathetic language. This can take the form of expressing humility, such as *we sometimes get things wrong* (12), and using offer or request forms like *I hope you'll* (13) and *If you would like* (14), which are relatively hedged when compared to imperatives like *Please contact* (8). It can also take the form of hospitable language like *you are very welcome to join* (14), while avoiding self-promotional language like *we pride ourselves in being a leader* (2), which suggests the writer is addressing the general public and not the individual patient who has left the feedback.

- Where possible, avoid including extended informational passages in the main body of the reply text, such as recited procedural information, as this is likely to drown out the voice of the individual writer and create an impersonal effect. Instead, include such information at the end of the reply or link to where the information can be found on a practice or hospital website: *here's a link to more information* (14).

- Be clear about the identity of the writer. This can be achieved by signing off the reply with a name and job title at the end; using first-person singular pronouns so that it is known who any reported feelings or actions can be attributed to; and only using first-person plural pronouns sparingly and when it is clear from the context that the speaker is

referring to themselves and colleagues and not to a personalised, abstract organisational identity.

- Try not to use unnecessary passive sentences; that is, passive sentences where the intention of the writer seems to be to produce a formal, professional-sounding register; for example, *Where necessary new procedures will be initiated* (5) when *we will initiate new procedures where necessary* could be used instead. Passive sentences can have the effect of obscuring who is doing what to whom, including with respect to relational and caring actions which in healthcare discourse, if anything, should be foregrounded.

- Prioritise referencing the patient and their experiences over self-referencing. While some self-referencing is necessary, a high amount of focus on staff actions and values relative to few references to the patient is likely to create a self-interested and uncaring effect. When referring to the individual patient, direct second-person pronouns (*you*, *your*) and generic third-person references should be used, such as *Patients can help us…* (6).

- Where possible, use verbs rather than nouns to foreground actions, such as when referring to patients' experiences. Therefore, *you were well looked after* (11) is preferable to *your experience* (9). Action can also be foregrounded by representing the scene of action, such as by referencing time and place: *when visiting the practice the other day* (11).

- When responding to positive feedback, use adjectives that attribute qualities to feedback and feelings to staff to make the language of replies more expressive; for example, general emotion words like *kind* (10), *happy* (11) and *lovely* (15). Use of affective language can help personalise replies by conveying the feelings of staff and expressing a caring attitude.

- Use the word *feedback* (10) rather than *comments* (1) (or *comment* or *review*), at least in the first instance of referring to patients' accounts of their experiences. This will help to emphasise how patients and staff are engaged in a collaborative activity when patients provide feedback that can potentially be used by staff to help improve healthcare services, whereas a comment or online review arguably represents a unilateral communicative action. The value of feedback as a collaboration can also be expressed through language that represents its usefulness, such as *helpful* (10) and *hope you'll use the website again to keep us posted about any future experiences* (13).

- Incorporate subtle conversational features into replies such as discourse markers like *For now, though* and *be sure to* (15) and contractions like *you'll* (13) and *I'll* (15). When

integrated with more formal features, these can help create a personalised, professional register that is best suited to this kind of communication.

It is important to stress that stock replies represent the least preferred option for responding to feedback. These recommendations are intended for instances where the constraints on staff resources may mean that the only alternative to stock replies is to not reply at all, in which case stock replies with a caring effect may be preferable to those that seem overly formulaic and uncaring. However, no matter what the style, any language that is overused for effect will eventually seem hackneyed and impersonal. A notable example is the expression 'have a nice day' associated with customer service behaviour and originally intended for politeness, which has come to represent insincerity through overuse.

The list of recommendations above apply to stock, mixed and unique replies. Their purpose is to support staff who have caring intentions and want these to be reflected in the language they use. They could be of particular use in a context where the strong influence of corporate and managerial norms may encourage an impersonal use of language, as has been found to be the case in a number of the findings reported in this thesis. However, making recommendations about how to personalise the style of language, especially when this does not accompany personalised content, is potentially problematic. This is because the recommended techniques might be adopted to create the effect of personalised responses, which could make it harder to identify instances where staff are simply going through the motions and, in fact, do not care in the way that their use of language suggests. In this way, recommendations about language can only achieve so much, and, ultimately, a change in attitude may be needed for many staff to view replies to feedback as a valuable space in which to engage with patients.

8.5 Dissemination

For the findings from this thesis to have an impact, I have engaged and will continue to engage in a number of dissemination activities. To date, this has included raising the profile of the research by presenting findings from the thesis at several academic conferences. These include talks at: the 39th Annual Conference of the International Computer Archive for Modern and Medieval English (ICAME 39) in May 2018; the Corpora and Discourse International Conference (CAD 2018) in June 2018; the International Corpus Linguistics Conference (CL 2019) in July 2019; and the Corpora and Discourse International Conference

(CAD 2020) in June 2020. I have also co-authored the book *The Language of Patient Feedback: A Corpus Linguistic Study of Online Health Communication* (Baker, Brookes and Evans, 2019), which includes a chapter that outlines some of the initial findings from this thesis.

Future dissemination activities I plan to carry out include publishing several papers from my PhD, including in at least one non-linguistics journal or magazine aimed at healthcare practitioners. The potential for this PhD research to have an impact on practice is supported by the fact that it is linked to a collaborative research project between Lancaster University and the NHS (see Chapter 1). In this way, the NHS has a vested interest in the research and an avenue of contact already exists for an important audience of the findings from this thesis. A copy of the thesis will be made available to the Senior Insight Account Manager at NHS England.

The influence of my research is also already reflected by the fact that it has influenced the development of new tools in the corpus software WordSmith 7 (the Duplicate Contents and Boilerplate Text functions). Over the course of my PhD I have liaised with the developer of WordSmith, Mike Scott, who created these new functions in WordSmith 7 to help address certain technical and methodological issues raised by my study. These are tools that can potentially be used by other researchers in future corpus-based studies.

8.6 Limitations of the study and future research potential

A focus of this thesis has been the likely interpersonal effects created when healthcare staff make certain discursive choices in their responses to online patient feedback. Judgements about such effects are based on generally accepted truths about how particular ways of using language are likely to have certain relational implications. For example, the use of polite linguistic forms will have a more positive effect than the use of linguistic forms associated with impoliteness. However, the likely interpersonal effect of some language use is not as clear-cut as this, as has been suggested in this thesis with respect to the use of a formal, professional register in staff replies.

While the serious and detached nature of a formal, professional register might seem impersonal and off-putting to some patients, there is also the possibility that others may

evaluate it positively as staff being professional. How patients interpret this register cannot be known by looking at staff language use in isolation. To create a more informed picture of how the language used by healthcare staff makes patients feel, it would be necessary to ask patients themselves. Therefore, a possible future research project would be to conduct interviews and surveys with patients and to use measures that rate their emotional response to different examples of language use identified in this thesis. Interviewing staff about their practices when replying to feedback would also be useful in gaining further insights into their intended meanings.

Time and space constraints have meant that the scope of this thesis has been mostly limited to staff replies. While it has included some of the original patient feedback that prompted replies in the analysis, this only occurs on an ad hoc basis. Primarily the focus has been on how healthcare staff use language, which is why limited space has been given to also examining how replies relate to feedback. However, the linguistic choices of staff in replies will to some extent be influenced by the language used by patients in their feedback.

The question of to what extent they are influenced by patient discourse remains to be answered, which suggests this could be the topic of a future research project that systematically analyses if and how discursive patterns in patient feedback correspond to patterns in staff replies to that feedback. One purpose of such research would be to identify whether how patients use language is a predictor of how staff use language in response. A component of such future research might be to also compare patient comments that received replies to those that did not. This could explore whether there are characteristics of feedback that affect its likelihood of receiving a response from staff.

Finally, a key innovation in this thesis also represents a limitation. The new approach to CADS used in this study, developed to address the high amount of text reuse in the corpus, is limited in the sense that it has not been tried and tested in the context of different studies. This means that decisions about cut-offs and the use of different statistical measures have been based on rationale specific to the data examined in this thesis, without the benefit of being able to evaluate the strengths and weaknesses of the use of such methods in similar previous research.

Therefore, a potential future study could carry out a more rigorous and large-scale systematic test of the new WordSmith 7 tools (Duplicate Contents and Boilerplate Text) used in this study, using different kinds of data. This would be with the aim of identifying optimal cut-offs and statistical measures, while also providing a more objective account of how effectively these tools support the discourse analysis of data containing large amounts of text reuse.

8.7 Final remarks

The general aim of this thesis has been to investigate how staff use language when replying to online patient feedback. In the course of addressing this aim by analysing staff replies and identifying the variety of ways that staff across the NHS use language, a recurring question has been: what is the purpose of staff when they reply to feedback? At the start, the notion of purpose seemed uncontroversial. Most likely, it would be along the lines of performing a courtesy when someone has gone to the trouble of providing feedback, or to address a reported incident with some form of explanation. Indeed, evidence of such expected purposes has been found in the analysis of staff replies, and to a large extent, there is no reason to question the worthwhileness of what staff are doing when they respond to feedback or what patients are doing when they provide an account of their healthcare experiences.

However, the question of purpose has become pressing when the investigation of staff replies has yielded interesting, and sometimes unexpected, findings about how healthcare staff use language; for example, the frequent tendency for staff to produce corporate-like value statements, such as *we value all patient feedback*. These seem like an odd way to address an individual in a healthcare context. The purpose of such statements seems to be to reassure the public about a practice's integrity and to let them know what the practice stands for as an organisation. It is not clear, though, whether the implied general audience of such replies is going to help the individual who provided the feedback feel particularly valued.

The question of purpose becomes even more pressing with other discoveries in the data; for example, the finding that staff sometimes seem to be using language in a way that is likely to antagonise patients, such as when they refer to them in the third person (e.g. *this patient*) to talk about them to a general public audience, as if they were not the one in fact receiving the reply to their feedback. At other times, staff use of sarcasm may be meant in good humour,

but when it is directed against the person who has left feedback it may well make them feel foolish and wonder why they bothered to leave feedback in the first place.

After reading many of the comments left by patients on NHS Choices, and encountering some that are very rude and highly critical, it is easy to appreciate why staff sometimes respond the way they do. However, when this amounts to a situation in which patients and staff are using the public space of a healthcare review website seemingly for one-upmanship, it begs the question: what is the point of it all?

A dominant feature of these staff replies has been text reuse. The frequent use of stock replies by staff may reflect that they are under-resourced and that they are trying to complete an administration task as quickly as possible, or it could be that they are doing the bidding of a manager or conforming to corporate norms by reproducing the same consistent organisational message. Whatever the reason, as with the other examples mentioned, this equates to a generally impersonal use of language that again raises a question about the purpose of replies. Ultimately, what is arguably needed is for healthcare staff to have the space, time and autonomy to reflect on why they are collecting and responding to feedback, whether it genuinely makes things better for patients and what more they can do, if anything, to help make the whole situation worthwhile.

References

Adams, M., Maben, J. and Robert, G. (2018). 'It's sometimes hard to tell what patients are playing at': How healthcare professionals make sense of why patients and families complain about care. *Health*, *22*(6), 603–23.

Adams, S. (2011). Sourcing the crowd for health services improvement: The reflexive patient and 'share-your-experience' websites. *Social Science and Medicine*, *72*, 1069–76.

Alshomary, M., Völske, M., Licht, T., Wachsmuth, H., Stein, B., Hagen, M. and Potthast, M. (2018). Wikipedia text reuse: Within and without. Available at: https://arxiv.org/abs/1812.09221.

Angelelli, C. (2014). Interpreting in the healthcare setting: Access in cross-linguistic communication. In H. Hamilton and W. Chou (Eds.), *The Routledge handbook of language and health communication* (pp. 573–85). London and New York: Routledge.

Ashforth, B. and Humphrey, R. (1993). Emotional labor in service roles: The influence of identity. *Academy of Management Review*, *18*(1), 88–115.

Asprey, A., Campbell, J., Newbould, J., Cohn, S., Carter, M., Davey, A. and Roland, M. (2013). Challenges to the credibility of patient feedback in primary healthcare settings: A qualitative study. *British Journal of General Practice*, *63*, 200–8.

Atanasova, D., Koteyko, N., Brown, B. and Crawford, P. (2019). Mental health and the media: From illness to wellbeing. *Sociology Compass*, *13*(5), 1–12.

Baines, R., Donovan, J., Regan de Bere, S., Archer, J. and Jones, R. (2018). Responding effectively to adult mental health patient feedback in an online environment: A coproduced framework. *Health Expectations*, *21*, 887–98.

Baker, P. (2006). *Using corpora in discourse analysis*. London: Bloomsbury.

Baker, P. (2010). *Sociolinguistics and corpus linguistics*. Edinburgh: Edinburgh University Press.

Baker, P. and Egbert, J. (Eds.) (2016). *Triangulating methodological approaches in corpus-linguistic research.* London: Routledge.

Baker, P. and McEnery, T. (2015). Introduction. In P. Baker and T. McEnery (Eds.), *Corpora and discourse studies: Integrating discourse and corpora* (pp. 1–19). Basingstoke: Palgrave Macmillan.

Baker, P., Brookes, G. and Evans, C. (2019). *The language of patient feedback: A corpus linguistic study of online health communication*. London: Routledge.

Baker, P., Gabrielatos, C., Khosravinik, M., Krzyzanowski, M., McEnery, T. and Wodak, R. (2008). A useful methodological synergy? Combining critical discourse analysis and corpus linguistics to examine discourses of refugees and asylum seekers in the UK press. *Discourse and Society*, *19*(3), 273–306.

Baldie, D., Guthrie, B., Entwistle, V. and Kroll, T. (2018). Exploring the impact and use of patients' feedback about their care experiences in general practice settings: A realist synthesis. *Family Practice*, *35*(1), 13–21.

BBC News (2016a). 'Patients at risk' from length of GP consultations. 29 August. Available at: www.bbc.co.uk/news/health-37211590.

BBC News (2016b). Receptionists 'put people off seeing doctor'. 11 October. Available at: www.bbc.co.uk/news/health-37605573.

Belinkov, Y., Magidow, A., Barrón-Cedeño, A., Shmidman, A. and Romanov, M. (2018). Studying the history of the Arabic language: Language technology and a large-scale historical corpus. Available at: https://arxiv.org/abs/1809.03891.

Benwell, B. and Stokoe, E. (2006). *Discourse and identity*. Edinburgh: Edinburgh University Press.

Berry, D. (2007). *Health communication: Theory and practice*. Maidenhead: Open University Press.

Bhatia, V. (1993). *Analysing genre: Language use in professional settings*. London: Routledge.

Biber, D. (2013). Register and discourse analysis. In J.P. Gee and M. Handford (Eds.), *The Routledge handbook of discourse analysis* (pp. 191–208). London: Routledge.

Biber, D. and Conrad, S. (2009). *Register, genre, and style*. Cambridge: Cambridge University Press.

Biber, D., Connor, U. and Upton, T. (2007). Identifying and analyzing rhetorical moves in philanthropic discourse. In D. Biber, U. Connor and T.A. Upton (Eds.), *Discourse on the move: Using corpus analysis to describe discourse structure* (pp. 43–72). Amsterdam: Benjamins.

Blatt, B., Spinazzi, N. and Greenberg, L. (2014). Communication skills training for resident physicians: A physician-educator perspective. In H. Hamilton and W. Chou (Eds.), *The Routledge handbook of language and health communication* (pp. 294–326). London and New York: Routledge.

Brashers, D., Haas, S., Klingle, R. and Neidig, J. (2000). Collective AIDS activism and individuals' perceived self-advocacy in physician-patient communication. *Human Communication Research*, *26*(2), 372–402.

Brooker, C. (Creator) (2016). *Nosedive*. Black Mirror. Available at: www.netflix.com/watch/80104627?trackId=13752289&tctx=0%2C0%2C171dae45-6616-4ba8-b13d-d178b332aea0-9598493.

Brookes, G. and Harvey, K. (2016). Opening up the NHS to market: Using multimodal critical discourse analysis to examine the ongoing commercialisation of health care. *Journal of Language and Politics*, *15*(3), 288–303.

Brookes, G., Harvey, K., Chadborn, N. and Dening, T. (2018). 'Our biggest killer': Multimodal discourse representations of dementia in the British press. *Social Semiotics*, *28*(3), 371–95.

Brown, B. and Crawford, P. (2009). Politeness strategies in question formulation in a UK telephone advisory service. *Journal of Politeness Research*, *5*(1), 73–91.

Brown, B., Crawford, P. and Carter, R. (2006). *Evidence-based health communication*. Maidenhead: Open University Press.

Brown, G. and Yule, G. (1983). *Discourse analysis.* Cambridge: Cambridge University Press.

Brown, P. and Levinson, S. (1987). *Politeness: Some universals in language usage*. Cambridge: Cambridge University Press.

Brown, P., Elston, M. and Gabe, J. (2015). From patient deference towards negotiated and precarious informality: An Eliasian analysis of English general practitioners' understandings of changing patient relations. *Social Science and Medicine*, *146*, 164–72.

Burgess, M., Giraudy, E., Katz-Samuels, J., Walsh, J., Willis, D., Haynes, L. and Ghani, R. (2016). The legislative influence detector: Finding text reuse in state legislation. *Proceedings of the 22nd ACM SIGKDD International Conference on Knowledge Discovery and Data Mining*, ACM, 57–66. Available at: www.kdd.org/kdd2016/papers/files/adf0831-burgessA.pdf.

Byrne, P. and Long, B. (1976). *Doctors talking to patients*. London: DHSS.

Cameron, D. (1997). Language: Are you being served? *Critical Quarterly*, *39*(2), 97–100.

Cameron, D. (2000). *Good to talk?* London: Sage.

Charon, R. (2006). The self-telling body. *Narrative Inquiry*, *16*(1), 191–200.

Charteris-Black, J. and Seale, C. (2010). *Gender and the language of illness*. Basingstoke: Palgrave Macmillan.

Cheraghi-Sohi, S. and Bower, P. (2008). Can the feedback of patient assessments, brief training, or their combination, improve the interpersonal skills of primary care physicians? A systematic review. *BMC Health Services Research*, *8*, 179.

Childs, C. and Walsh, D. (2017). Self-disclosure and self-deprecating self-reference: Conversational practices of personalization in police interviews with children reporting alleged sexual offenses. *Journal of Pragmatics*, *121*, 188.

Chorzempa, M., Triolo, P. and Sacks, S. (2018). *China's social credit system: A mark of progress or a threat to privacy?* Policy Briefs PB18-14, Peterson Institute for International Economics.

Citron, D. and Ginsparg, P. (2014). Patterns of text reuse in a scientific corpus. *Proceedings of the National Academy of Sciences*. doi: 10.1073/pnas.1415135111.

Cleary, P.D. (1998). Satisfaction may not suffice! A commentary on 'a patient's perspective'. *International Journal of Technology Assessment in Health Care*, *14*(1), 35–7.

Cleary, P. (1999). The increasing importance of patient surveys. *British Medical Journal*, *319*, 720.

Colavizza, G., Infelise, M. and Kaplan, F. (2015). Mapping the early modern news flow: An enquiry by robust text reuse detection. In L. Aiello and D. McFarland (Eds.), *Social informatics. SocInfo 2014. Lecture notes in computer science*, vol. 8852. Cham: Springer. https://doi.org/10.1007/978-3-319-15168-7_31.

Costello, C. and Charlesworth, L. (2017). Embedding feedback into maternity services at Calderdale and Huddersfield NHS Foundation Trust. Available at: https://healthwatchkirklees.co.uk/wp-content/uploads/2016/11/FINAL-Embedding-feedback-in-maternity-services-at-CHFT-1.pdf.

Coulter, A. (2006). Can patients assess the quality of health care? *British Medical Journal*, *333*, 1–2.

Coulter, A. (2013). Understanding the experience of illness and treatment. In S. Ziebland, A. Coulter, J. Calabrese and L. Locock (Eds.), *Understanding and using health experiences*. Oxford: Oxford University Press.

Coulter, A., Fitzpatrick, R. and Cornwell, J. (2009). *Measures of patients' experience in hospital: Purpose, methods and uses*. The King's Fund. Available at: www.kingsfund.org.uk/sites/default/files/Point-of-Care-Measures-of-patients-experience-in-hospital-Kings-Fund-July-2009_0.pdf.

Coulter, A., Locock, L., Ziebland, S. and Galabrese, J. (2014). Collecting data on patient experience is not enough: They must be used to improve care. *British Medical Journal*, *348*, 2225.

Coupland, J., Robinson, J. and Coupland, N. (1994). Frame negotiation in doctor-patient frame consultations. *Discourse and Society*, *5*(1), 89–124.

Coupland, N. (2010). Accommodation theory. In J. Jaspers, J. Verschueren and J. Östman (Eds.), *Society and language use* (pp. 21–7). Amsterdam: Benjamins.

Crawford, P., Gilbert, P., Gilbert, J., Gale, C. and Harvey, K. (2013). The language of compassion in acute mental health care. *Qualitative Health Research*, *23*, 719–27.

Crawford, P., Brown, B., Adolphs, S., Bissell, P., Plant, N., Sahota, O. and Carter, R. (2004). *Compliance, concordance and 'Corpus Linguistics': Towards a new paradigm in the study of clinical encounters*. Nottingham: Health Language Research Group.

Cross, J.P. and Hermansson, H. (2017). Legislative amendments and informal politics in the European Union: A text reuse approach. *European Union Politics*, *18*(4), 581–602.

Demjen, Z., Marszalek, A., Semino, E. and Varese, F. (2017). Linguistic manifestations of power and control in lived-experience accounts of voice-hearing. Presented at BAAL Health

& Science Communication SIG Workshop on Chronic Disease and Language: Understanding Social and Linguistic Representations to Improve Treatment and Prevention. Lancaster University.

Deppermann, A. and Spranz-Fogasy, T. (2011). Doctors' questions as displays of understanding. *Communication & Medicine*, *8*(2), 111–22.

de Silva, J., Slade, D., Bateson, D., Scheeres, H., McGregor, J. and Weisberg, E. (2015). Patient-centred discourse in sexual and reproductive health consultations. *Discourse and Communication*, *9*(3), 275–92.

Doig, G. (2004). Responding to formal complaints about the emergency department: Lessons from the service marketing literature. *Emergency Medicine Australasia*, *16*, 353–60.

Drew, P., Chatwin, J. and Collins, S. (2001). Conversation analysis: A method for research into interactions between patients and health-care professionals. *Health Expectations*, *4*, 58–70.

Dunn, C. (2006). Formulaic expressions, Chinese proverbs, and newspaper editorials: Exploring type and token interdiscursivity in Japanese wedding speeches. *Journal of Linguistic Anthropology*, *16*(2), 153–72.

Ekberg, K. and Reuber, M. (2016). Can conversation analytic findings help with differential diagnosis in routine seizure clinic interactions? *Communication and Medicine*, *12*(1), 13–24.

Erman, B. and Warren, B. (2000). The idiom principle and the open choice principle. *Text*, *20*, 29–62.

Evans, R., Edwards, A., Evans, S., Elwyn, B. and Elwyn, G. (2007). Assessing the practising physician using patient surveys: A systematic review of instruments and feedback methods. *Family Practice*, *24*, 117–27.

Fairclough, N. (1985). Critical and descriptive goals in discourse analysis. *Journal of Pragmatics*, *9*(6), 739–63.

Fairclough, N. (1992). *Discourse and social change*. Cambridge: Polity Press.

Fairclough, N. (1993). Critical discourse analysis and the marketization of public discourse: The universities. *Discourse & Society*, *4*(2), 133–68.

Fairclough, N. (1994). Conversationalization of public discourse and the authority of the consumer. In K. Russell, N. Whiteley and N. Abercrombie (Eds.), *The authority of the consumer*. London: Routledge.

Fairclough, N. (2001). *Language and power* (2nd ed.). London: Longman.

Fitzpatrick, R. (1991). Surveys of patient satisfaction: I-Important general considerations. *British Medical Journal*, *302*, 887–9.

Flowerdew, J. (2012). *Discourse in English language education*. London: Routledge.

Forsyth, L. and Grabowski, R. (2015). Is there a formula for formulaic language? *Poznan Studies in Contemporary Linguistics*, *51*(4), 1–38.

Foucault, M. (1969). *Archaeology of knowledge and the discourse on language* (trans. A.M. Sheridan Smith, 1972). Paris: Éditions Gallimard.

Foucault, M. (1975). *Discipline and punish: The birth of the prison*. New York: Random House.

Gabrielatos, C. (2018). Keyness analysis: Nature, metrics and techniques. In C. Taylor and A. Marchi (Eds.), *Corpus approaches to discourse: A critical review* (pp. 225–58). London: Routledge.

Gardner, S. (2004). Knock-on effects of mode change in academic discourse. *Journal of English for Academic Purposes*, *3*(1), 22–38.

Giles, H. and Ogay, T. (2007). Communication accommodation theory. In B.B. Whaley and W. Samter (Eds.), *Explaining communication: Contemporary theories and exemplars* (pp. 293–310). Mahwah, NJ: Lawrence Erlbaum.

Ginns, P., Martin, A.J. and Marsh, H.W. (2013). Designing instructional text in a conversational style: A meta-analysis. *Educational Psychology Review*, *25*(4), 445–72.

Gleeson, H., Calderon, A., Swami, V., Deighton, J., Wolpert, M. and Edbrooke-Childs, J. (2016). Systematic review of approaches to using patient experience data for quality improvement in healthcare settings. *BMJ Open*, *6*, e011907.

Goffman, E. (Ed.) (1967). *Interaction ritual: Essays on face-to-face behavior*. Garden City, NY: Anchor Books.

Graham, C. and Woods, P. (2013). Patient experience surveys. In S. Ziebland, A. Coulter, J. Calabrese and L. Locock (Eds.), *Understanding and experiencing health experiences* (pp. 81–93). Oxford: Oxford University Press.

Grainger, K., Masterson, S. and Jennings, M. (2005). 'Things aren't the same, are they?': The management of bad news delivery in the discourse of stroke care. *Communication & Medicine*, *2*(1), 35–44.

Greenhalgh, T. and Hurwitz, B. (1998). *Narrative-based medicine*. London: BMJ Books.

Gremler, D.D. and Gwinner, K.P. (2000). Customer-employee rapport in service relationships. *Journal of Service Research*, *3*(1), 82–104.

Hagen, M., Potthast, M., Adineh, P., Fatehifar, E. and Stein, B. (2017). Source retrieval for web-scale text reuse detection. *Proceedings of CIKM 2017*, 2091–4.

Halliday, M. (1973). The functional basis of language. In M. Halliday, *On language and linguistics*. London: Bloomsbury.

Hamilton, H. and Chou, S. (2014). *The Routledge handbook of language and health communication.* London and New York: Routledge.

Hardie, A. (2012). CQPweb: Combining power, flexibility and usability in a corpus analysis tool. *International Journal of Corpus Linguistics*, *17*(3), 380–409.

Hardt-Mautner, G. (1995). *Only connect: Critical discourse analysis and corpus linguistics*. UCREL Technical Paper 6. Lancaster University.

Harrison, S. and Barlow, J. (2009). Politeness strategies and advice-giving in an online arthritis workshop. *Journal of Politeness Research Language Behaviour Culture*, 5(1), 93–111.

Harvey, K. (2012). Disclosures of depression: Using corpus linguistics methods to interrogate young people's online health concerns. *International Journal of Corpus Linguistics*, *17*(3), 349–79.

Harvey, K. and Brown, B. (2012). Health communication and psychological distress: Exploring the language of self-harm. *The Canadian Modern Language Review*, *68*(3), 316–40.

Harvey, K. and Koteyko, N. (2012). *Exploring health communication: Language in action*. Abingdon: Routledge.

Hennig-Thurau, T., Qwinner, K.P., Walsh, G. and Gremler, D.D. (2004). Electronic word-of-mouth via consumer-opinion platforms: What motivates consumers to articulate themselves on the Internet? *Journal of Interactive Marketing*, *18*(1), 38–52.

Heritage, J. and Sefi, S. (1992). Dilemmas of advice: Aspects of the delivery and reception of advice in interactions between health visitors and first-time mothers. In P. Drew and J. Heritage (Eds.), *Talk at work: Interaction in institutional settings* (pp. 359–417). Cambridge: Cambridge University Press.

Hewett, D., Watson, B., Gallois, C., Ward, M. and Leggett, B. (2009). Communication in medical records. *Journal of Language and Social Psychology*, *28*, 119–38.

Hewitt, H., McCloughan, L. and McKinstry, B. (2009). Front desk talk: Discourse analysis of receptionist–patient interaction. *British Journal of General Practice*, *59*, 571–7.

Hochschild, A. (1983). *The managed heart: The commercialisation of human feeling*. Berkeley, CA: University of California Press.

Hocking, D. (2015). The use of corpus analysis in a multi-perspectival study of creative practice. In P. Baker and T. McEnery (Eds.), *Corpora and discourse studies: Integrating discourse and corpora* (pp. 192–219). Basingstoke: Palgrave Macmillan.

Holmes, J. and Sigley, R. (2001). What's a word like girl doing in a place like this? In A. Smith and P. Peters (Eds.), *New frontiers of corpus linguistics* (pp. 247–63). Amsterdam: Rodopi.

Hunston, S. (2002). *Corpora in applied linguistics*. Cambridge: Cambridge University Press.

Hunston, S. (2010). Evaluative language, phraseology and corpus linguistics. In S. Hunston, *Corpus approaches to evaluation: Phraseology and evaluative language*. London: Routledge.

Hunt, D. and Harvey, K. (2015). Health communication and corpus linguistics: Using corpus tools to analyse eating disorder discourse online. In P. Baker and T. McEnery (Eds.), *Corpora and discourse studies: Integrating discourse and corpora* (pp. 134–54). Basingstoke: Palgrave Macmillan.

Hunt, D. and Koteyko, N. (2015). 'What was your blood sugar reading this morning?' Representing diabetes self-management on Facebook. *Discourse and Society*, *26*(4), 445–63.

Hunt, D., Koteyko, N. and Gunter, B. (2015). UK policy on social networking sites and online health: From informed patient to informed consumer? *Digital Health*, *1*, 1–12.

Iedema, R. (2005). Critical incident reporting and the discursive reconfiguration of feeling and positioning. *Journal of Applied Linguistics*, *2*(3), 325–49.

Iedema, R. (2014). Clinical incident reporting, incident investigation, and incident disclosure. In H. Hamilton and W. Chou (Eds.), *The Routledge handbook of language and health communication* (pp. 407–20). London and New York: Routledge.

Iedema, R. and Merrick, E. (2016). Analysing teamwork in health care: What matters when clinicians negotiate the continuity of clinical tasks and care responsibilities? *Communication and Medicine*, *13*(1), 85–97.

Jaworski, A. and Coupland, N. (2006). *The discourse reader* (2nd ed.). Abingdon: Routledge.

Jones, R. (2012). *Discourse analysis*. London: Routledge.

Jones, R. (2014). Health risks and mediated discourse: A case study of 'AIDS in action'. In H. Hamilton and W. Chou (Eds.), *The Routledge handbook of language and health communication* (pp. 109–22). London and New York: Routledge.

Kang, S. (2017). Evidential adverbs of clearly and obviously: A corpus-based analysis. *SNU Working Papers in English Linguistics and Language*, *15*, 68–79.

Kilgarriff, A., Rundell, M. and Uí Dhonnchadha, E. (2006). Efficient corpus development for lexicography: Building the new corpus for Ireland. *Language Resources and Evaluation*, *40*(2), 127–52.

Kitson, A., Marshall, A., Bassett, K. and Zeitz, K. (2012). What are the core elements of patient-centred care? A narrative review and synthesis of the literature from health policy, medicine and nursing. *Journal of Advanced Nursing*, *25*(1), 4–15.

Knupsky, A. and Nagy-Bell, N. (2011). Dear Professor: The influence of recipient sex and status on personalization and politeness in e-mail. *Journal of Language and Social Psychology*, *30*(1), 103.

Koenig, C., Wingard, L., Sabee, C., Olsher, D. and Vandergriff, I. (2014). Managing patient-centered communication across the Type 2 diabetes illness trajectory: A grounded practical theory of interactional sensitivity. *Journal of Applied Communication Research*, *42*(3), 1–24.

Koteyko, N., Nerlich, B., Crawford, P. and Wright, N. (2008). 'Not rocket science' or 'No silver bullet'? Media and government discourses about MRSA and cleanliness. *Applied Linguistics*, *29*(2), 223–43.

Leanza, Y. (2005). Roles of community interpreters in pediatrics as seen by interpreters, physicians and researchers. *Interpreting*, *7*(2), 67–92.

Leskovec, J., Rajaraman, A. and Ullman, J. (2014). *Mining massive datasets*. Cambridge: Cambridge University Press.

Linder, F., Desmarais, B., Burgess, M. and Giraudy, E. (2018). Text as policy: Measuring policy similarity through bill text reuse. *Policy Studies Journal*. doi: 10.1111/psj.12257.

Locher, M. (2010). Health Internet sites: A linguistic perspective on health advice columns. *Social Semiotics*, *20*(1), 43–59.

Locher, M. (2014). The relational aspect of language: Avenues of research. In S. Mergenthal and R.M. Nischik (Eds.), *Anglistentag 2013 Konstanz: Proceedings* (pp. 309–22). Trier: Wissenschaftlicher Verlag Trier.

Locher, M. and Hoffman, S. (2006). The emergence of the identity of a fictional expert advice-giver in an American advice column. *Text and Talk*, *26*, 69–106.

Locher, M. and Schnurr, S. (2017). (Im)politeness in health settings. In J. Culpeper, M. Haugh and D. Kadar (Eds.), *The Palgrave handbook of linguistic (im)politeness*. London: Palgrave.

Locher, M.A. and Watts, R.J. (2005). Politeness theory and relational work. *Journal of Politeness Research*, *1*(1), 9–33.

Locher, M.A. and Watts, R.J. (2008). Relational work and impoliteness: Negotiating norms of linguistic behaviour. In D. Bousfield and M.A. Locher (Eds.), *Impoliteness in language: Studies on its interplay with power in theory and practice* (pp. 77–99). Berlin: Mouton de Gruyter.

Locock, L., Skea, Z., Alexander, G., Hiscox, C., Laidlaw, L. and Shepherd, J. (2020). Anonymity, veracity and power in online patient feedback: A quantitative and qualitative analysis of staff responses to patient comments on the 'Care Opinion' platform in Scotland. *Digital Health*, *6*, 1–13.

Louw, B. (1993). Irony in the text or insincerity in the writer? The diagnostic potential of semantic prosodies. In M. Baker, G. Francis and E. Tognini-Bonelli (Eds.), *Text and technology* (pp. 157–76). Amsterdam: Benjamins.

Lovestam, E., Fjellstrom, C., Koochek, A. and Andersson, A. (2015). The power of language on patient-centredness: Linguistic devices in the dietetic notes of patient records. *International Journal of Applied Linguistics*, *25*(2), 225–45.

Lucius-Hoene, G., Thiele, U., Breuning, M. and Haug, S. (2012). Doctors' voices in patients' narratives: Coping with emotions in storytelling. *Chronic Illness*, *8*(3), 163–75.

Lulu, L., Belkhouche, B. and Harous, S. (2016). Overview of fingerprinting methods for local text reuse detection. *Proceedings of the 2016 12th International Conference on Innovations in Information Technology (IIT)*. doi: 10.1109/INNOVATIONS.2016.7880050.

Lutfey, K. (2004). Assessment, objectivity, and interaction: The case of patient compliance with medical treatment regimens. *Social Psychology Quarterly*, *67*(4), 343–68.

Ma, J. and Stahl, L. (2017). A multimodal critical discourse analysis of anti-vaccination information on Facebook. *Library and Information Science Research*, *39*, 303–10.

Maíz-Arévalo, C. (2013). 'Just click "Like"': Computer-mediated responses to Spanish compliments. *Journal of Pragmatics*, *51*, 47–67.

Major, G. and Holmes, J. (2008). How do nurses describe health care procedures? Analysing nurse-patient interaction in a hospital ward. *Australian Journal of Advanced Nursing*, *25*(4), 58–70.

Manuti, A., Arcidiacono, C., Esposito, M. and Mininni, G. (2013). Creating supportive relationships: A study on call center discursive interactions between cancer patients and healthcare personnel. *Journal of Applied Linguistics and Professional Practice*, *10*(2), 151–76.

Marchi, A. and Taylor, C. (2018). Introduction: Partiality and reflexivity. In A. Marchi and C. Taylor (Eds.), *Corpus approaches to discourse: A critical review* (pp. 1–15). London: Routledge.

Marquez Reiter, R. and Bou-Franch, P. (2017). (Im)politeness in service encounters. In J. Culpeper, M. Haugh and D. Kádár (Eds.), *The Palgrave handbook of linguistic (im)politeness*. Basingstoke: Palgrave Macmillan.

Maseide, P. (2007). Discourses of collaborative medical work. *Text and Talk*, *27*, 611–32.

Mautner, G. (2005). The entrepreneurial university: A discursive profile of a higher education buzzword. *Critical Discourse Studies*, *2*(2), 1–26.

Maynard, D. and Hudak, P. (2008). Small talk, high stakes: Interactional disattentiveness in the context of prosocial doctor-patient interaction. *Language in Society*, *37*, 661–88.

Mazanderani, F. and Powell, J. (2013). Using the internet as a source of information about patients' experiences. In S. Ziebland, A. Coulter, J. Calabrese and L. Locock (Eds.), *Understanding and experiencing health experiences* (pp. 94–102). Oxford: Oxford University Press.

McEnery, T. (2006). *Swearing in English: Bad language, purity and power from 1586 to the present.* London: Routledge.

McEnery, T. and Hardie, A. (2012). *Corpus linguistics: Method, theory and practice*. Cambridge: Cambridge University Press.

McEnery, T. and Wilson, A. (2001). *Corpus linguistics* (2nd ed.). Edinburgh: Edinburgh University Press.

Mirador, J. (2000). A move analysis of written feedback in higher education. *RELC Journal*, *31*(1), 45–60.

Mishler, E. (1984). *The discourse of medicine: Dialectics of medical interviews*. Norwood, NJ: Ablex.

Monaghan, L., Rich, E. and Bombak, A. (2019). Media, 'fat panic' and public pedagogy: Mapping contested terrain. *Sociology Compass*, *13*, 1–17.

Moskovitz, C. (2017). Text recycling in health sciences research literature: A rhetorical perspective. *Research Integrity and Peer Review*, *2*(1), 1–7.

National Institute for Health Research (2019). *Improving care by using patient feedback*. Available at: https://content.nihr.ac.uk/nihrdc/themedreview-04327-PE/Patient-Feedback-WEB.pdf.

Nursing in Practice (2007). DH launches new 'NHS Choices' website to 'extend choice to all communities'. Available at: www.nursinginpractice.com/dh-launches-new-nhs-choices-website-extend-choice-all-communities.

O'Grady, C., Dahm, M., Roger, P. and Yates, L. (2013). Trust, talk and the dictaphone: Tracing the discursive accomplishment of trust in a surgical consultation. *Discourse and Society*, *25*(1), 65–83.

Ojwang, B.O., Matu, P.M. and Ogutu, E.A. (2010). Face attack and patients' response strategies in a Kenyan hospital. *Journal of Sociolinguistics*, *14*(4), 501–23.

Olsson, J. (2004). *Forensic linguistics: An introduction to language, crime and the law*. London: Continuum.

O'Reilly, D. and Reed, M. (2011). The grit in the oyster: Professionalism, managerialism and leaderism as discourses of UK public services modernization. *Organization Studies*, *32*(8), 1079–101.

Park, S. and Allen, J. (2013). Responding to online reviews: Problem solving and engagement in hotels. *Cornell Hospitality Quarterly*, *54*(1), 64–73.

Partington, A., Duguid, A. and Taylor, C. (2013). *Patterns and meanings in discourse theory and practice in corpus-assisted discourse studies (CADS).* Amsterdam: John Benjamins.

Pecina, P., Toral, A., Papavassiliou, V., Prokopidis, P., Tamchyna, A., Way, A. and Van Genabith, J. (2014). Domain adaptation of statistical machine translation using web-crawled resources and model parameter tuning. *Language Resources and Evaluation*, *49*(1), 147–93.

Pedersen, S., Razmerita, L. and Colleoni, E. (2014). Electronic word-of-mouth communication and consumer behaviour: An exploratory study of Danish social media communication influence. *LSP Journal: Language for Special Purposes, Professional Communication, Knowledge Management, and Cognition*, *5*(1), 112–31.

Pinto, D. (2011). Are Americans sincere? Interactional style and politeness in everyday America. *Journal of Politeness Research: Language, Behaviour, Culture*, *7*(2), 215–38.

Pounds, G. (2018). Patient-centred communication in ask-the-expert health-care websites. *Applied Linguistics*, *39*, 117–34.

Prestin, A. and Chou, W. (2014). Web 2.0 and the changing health communication environment. In H. Hamilton and W. Chou (Eds.), *The Routledge handbook of language and health communication* (pp. 184–97). London and New York: Routledge.

Ramsey, L.P., Sheard, L., Lawton, R. and O'Hara, J. (2019). How do healthcare staff respond to patient experience feedback online? A typology of responses published on Care Opinion. *Patient Experience Journal*, *6*(2), 42–50.

Rayson, P. (2008). From keywords to key semantic domains. *International Journal of Corpus Linguistics*, *13*(4), 519–49.

Reinders, M.E., Ryan, B.L., Blankenstein, A.H., van der Horst, H.E., Stewart, M.A. and van Marwijk, H.W. (2011). The effect of patient feedback on physicians' consultation skills: A systematic review. *Academic Medicine*, *86*, 1426–36.

Schafer, R. (2017). Accurate and efficient general-purpose boilerplate detection for crawled web corpora. *Language Resources and Evaluation*, *51*(3), 873–89.

Schreiner, M. (2014). Mirroring. Available at: https://evolutioncounseling.com/mirroring.

Schryer, C., Gladkover, O., Spafford, M. and Lingard, L. (2007). Co-management in healthcare: Negotiating professional boundaries. *Discourse and Communication*, *1*(4), 452–79.

Scott, M. (2016). *WordSmith Tools version 7*. Stroud: Lexical Analysis Software.

Seale, C. Ziebland, S. and Charteris-Black, J. (2006). Gender, cancer experience and internet use: A comparative keyword analysis of interviews and online cancer support groups. *Social Science & Medicine*, *62*(10), 2577–90.

Semino, E. and Demjen, Z. (2017). The cancer card: Metaphor, intimacy and humor in online interactions about the experience of cancer. In B. Hampe (Ed.), *Metaphor: Embodied cognition and discourse* (pp. 181–99). Cambridge: Cambridge University Press.

Semino, E., Demjen, Z., Demmen, J., Koller, V., Payne, S., Hardie, A. and Rayson, P. (2017). The online use of Violence and Journey metaphors by patients with cancer, as compared with health professionals: A mixed methods study. *BMJ Supportive and Palliative Care*, *7*(1), 60–6.

Sharjeel, M., Nawab, R. and Rayson, P. (2017). COUNTER: Corpus of Urdu News Text Reuse. *Language Resources and Evaluation*, *51*, 777–803.

Sheard, L., Marsh, C., O'Hara, J., Armitage, G., Wright, J. and Lawton, R. (2017). The patient feedback response framework: Understanding why UK hospital staff find it difficult to make improvements based on patient feedback – A qualitative study. *Social Science & Medicine*, *178*, 19–27.

Sinclair, J. (1991). *Corpus, concordance, collocation*. Oxford: Oxford University Press.

Smith, D., Cordell, R., Dillon, E., Stramp, N. and Wilkerson, J. (2014). Detecting and modeling local text reuse. *Proceedings of the 14th ACM/IEEE-CS Joint Conference on Digital Libraries*, 183–92.

Soto, A., Mohammad, A., Albert, A., Islam, A., Milios, E. and Doyle, M. (2015). Similarity-based support for text reuse in technical writing. *Proceedings of the 2015 ACM Symposium on Document Engineering*, DocEng 15, 97–106.

Sousa-Silva, R. (2015). 'Reporter fired for plagiarism': A forensic linguistic analysis of news plagiarism. In A. Simões, A. Barreiro, D. Santos, R. Sousa-Silva and S.E.O. Tagnin (Eds.), *Linguística, Informática e Tradução: Mundos que se Cruzam*. *Oslo Studies in Language*, *7*(1), 301–22.

Sparks, B., So, K. and Bradley, G. (2016). Responding to negative online reviews: The effects of hotel responses on customer inferences of trust and concern. *Tourism Management*, *53*, 74–85.

Speed, E., Davison, C. and Gunnell, C. (2016). The anonymity paradox in patient engagement: Reputation, risk and web-based public feedback. *Medical Humanities*, *42*, 135–40.

Spoel, P. (2010). The rhetorical work of informed choice in midwifery: Situated knowledges and the negotiation of health care decisions. In R. Harris, N. Wathen and S. Wyatt (Eds.),

Configuring health consumers: Health work and the imperative of personal responsibility. Basingstoke: Palgrave Macmillan.

Steehouder, M.F. (2005). Using role sets to engage and persuade visitors of websites that promote safe sex. *Proceedings of the International Professional Communication Conference, 2005*, 188–95.

Stokoe, E., Sikveland, R. and Symonds, J. (2016). Calling the GP surgery: Patient burden, patient satisfaction, and implications for training. *The British Journal of General Practice: The Journal of The Royal College of General Practitioners*, 66(652), e779–e785.

Stubbs, M. (1983). *Discourse analysis: The sociolinguistic analysis of natural language*. Chicago, IL: University of Chicago Press.

Sturgeon, D. (2014). The business of the NHS: The rise and rise of consumer culture and commodification in the provision of healthcare services. *Critical Social Policy*, *34*(3), 405–16.

Swales, J. (1990). *Genre analysis: English in academic and research settings*. Cambridge: Cambridge University Press.

Swales, J. (2004). *Research genres: Exploration and applications*. Cambridge: Cambridge University Press.

Swinglehurst, D. and Roberts, C. (2014). The role of the electronic patient record in the clinical consultation. In H. Hamilton and W. Chou (Eds.), *The Routledge handbook of language and health communication* (pp. 490–505). London and New York: Routledge.

Swinglehurst, D., Roberts, C. and Greenhalgh, T. (2011). Opening up the 'black box' of the electronic patient record: A linguistic ethnographic study in general practice. *Communication and Medicine*, *8*(1), 1–12.

Tátrai, S. and Csontos, N. (2017). Perspectivization and modes of quoting in Hungarian. *Acta Linguistica Hungarica*, *56*(4), 441–68.

Taylor, C. (2015). Beyond sarcasm: The metalanguage and structures of mock politeness. *Journal of Pragmatics*, *87*, 127–41.

ten Have, P. (1989). The consultation as a genre. In B. Torode (Ed.), *Text and talk as social practice*. Dordrecht: Foris.

The Daily Mail (2007). Patients to post 'customer reviews' of the NHS online. 19 June. Available at: www.dailymail.co.uk/health/article-463001/Patients-post-customer-reviews-NHS-online.html.

The Guardian (2013). The NHS will fail us so long as we look on it as a market. 8 August. Available at: www.theguardian.com/commentisfree/2013/aug/08/nhs-market-impossible-expecations.

The Guardian (2015). Reputation and the rise of the 'rating' society. 26 October. Available at: www.theguardian.com/media-network/2015/oct/26/reputation-rating-society-uber-airbnb.

The Guardian (2016). Are you ready for a future where we're all reviewed like Uber drivers? 15 March. Available at: www.theguardian.com/technology/commentisfree/2016/mar/15/rating-culture-score-personal-privacy-uber-sharing-economy.

The Guardian (2018a). Hospital trusts accused of 'backdoor privatisation'. 16 April. Available at: www.theguardian.com/society/2018/apr/16/hospital-trusts-accused-of-backdoor-privatisation.

The Guardian (2018b). NHS suffering worst ever staff and cash crisis, figures show. 11 September. Available at: www.theguardian.com/society/2018/sep/11/nhs-suffering-worst-ever-staff-cash-crisis-figures-show.

The Times (2016). Abrupt GP receptionists are suspected of filling up A&E. 16 August. Available at: www.thetimes.co.uk/article/abrupt-gp-receptionists-are-suspected-of-filling-up-a-amp-e-blqd3xzwg.

Tognini-Bonelli, T. (2001). *Corpus linguistics at work*. Amsterdam: John Benjamins.

Tognini-Bonelli, T. (2010). Theoretical overview of the evolution of corpus linguistics. In A. O'Keeffe and M. McCarthy (Eds.), *The Routledge handbook of corpus linguistics*. London: Routledge.

Tsai, M., Lu, F. and Frankel, R. (2014). Teaching medical students to become discourse analysts: From conversational transcripts to clinical applications. In H. Hamilton and W. Chou (Eds.), *The Routledge handbook of language and health communication* (pp. 327–43). London and New York: Routledge.

Vasquez, C. (2014). *The discourse of online consumer reviews*. London: Bloomsbury Academic.

Veinot, T. (2010). Power to the patient? A critical examination of patient empowerment discourses. In R. Harris, N. Wathen and S. Wyatt (Eds.), *Configuring health consumers: Health work and the imperative of personal responsibility*. Basingstoke: Palgrave Macmillan.

Vergaro, C. (2004). Discourse strategies of Italian and English sales promotion letters. *English for Specific Purposes*, *23*(2), 181–207.

Villagran, M. and Baldwin, P. (2014). Healthcare team communication. In H. Hamilton and W. Chou (Eds.), *The Routledge handbook of language and health communication* (pp. 362–74). London and New York: Routledge.

Wessel, J. and Steiner, D. (2015). Surface acting in service: A two context examination of customer power and politeness. *Human Relations*, *68*(5), 709–30.

Wessely, B. and Gerada, C. (2016). You are being watched: Panopticons in healthcare. *British Medical Journal*, *352*, h6777.

Widdowson, H.G. (2004). *Text, context, pretext: Critical issues in discourse analysis*. Oxford: Blackwell.

Wilkerson, J., Smith, D. and Stramp, N. (2015). Tracing the flow of policy ideas in legislatures: A text reuse approach. *American Journal of Political Science*, *59*(4), 943–56.

Wodak, R. and Meyer, M. (2009). *Methods of critical discourse studies*. London: Sage.

WordSmith Tools Manual (2016). Introduction to WordSmith Tools. Available at: https://lexically.net/downloads/version7/HTML/index.html.

Zhang, Y. and Vásquez, C. (2014). Hotels' responses to online reviews: Managing consumer dissatisfaction. *Discourse, Context and Media*, *6*, 54–64.

Appendices

Appendix 1: Top 50 keywords of unique replies

Number	Keyword	Unique replies		Reference corpus		
		Frequency (absolute)	Frequency (per mill.)	Frequency (absolute)	Frequency (per mill.)	Log-likelihood
1	a	55,412	15,251.76	71,681	9,869.95	5838.4
2	not	23,801	6,551.06	26,524	3,652.16	4200.58
3	appointments	13,802	3,798.90	12,819	1,765.08	3858.12
4	but	9,163	2,522.05	7,543	1,038.62	3249.54
5	is	36,951	10,170.50	50,226	6,915.75	3113.5
6	in	40,342	11,103.85	56,163	7,733.23	3025.12
7	as	23,524	6,474.81	28,997	3,992.67	2972.61
8	appointment	12,411	3,416.04	13,066	1,799.09	2565.88
9	of	51,414	14,151.34	77,148	10,622.72	2512.73
10	an	13,350	3,674.49	14,566	2,005.63	2500.73
11	patients	26,803	7,377.33	35,865	4,938.35	2423.3
12	there	7,238	1,992.21	6,303	867.88	2307.85
13	doctor	5,863	1,613.75	4,639	638.76	2228.21
14	day	8,081	2,224.24	8,057	1,109.39	1917.67
15	this	37,079	10,205.73	55,200	7,600.64	1900.11
16	system	7,039	1,937.43	6,907	951.04	1735.23
17	only	3,632	999.68	2,681	369.15	1545.94
18	over	3,268	899.49	2,382	327.98	1418.47
19	waiting	3,090	850.5	2,177	299.76	1411.63
20	however	5,066	1,394.38	4,773	657.21	1370.15
21	some	4,938	1,359.15	4,725	650.6	1289.91
22	new	4,756	1,309.06	4,495	618.93	1277.31
23	other	3,502	963.9	2,879	396.42	1243.68
24	see	5,897	1,623.11	6,188	852.04	1228.22
25	which	9,431	2,595.82	11,544	1,589.52	1219.04
26	hours	2,338	643.52	1,499	206.4	1217.8
27	no	2,839	781.41	2,108	290.26	1197.13
28	has	9,650	2,656.09	11,965	1,647.49	1189.6
29	seen	3,251	894.81	2,672	367.91	1155
30	week	2,124	584.62	1,334	183.68	1136.35
31	unfortunately	2,978	819.67	2,358	324.68	1129.8
32	doctors	4,191	1,153.54	3,973	547.05	1117.88
33	prescription	1,668	459.11	864	118.97	1114.72
34	due	2,583	710.95	1,892	260.51	1112.53
35	reception	5,641	1,552.65	6,059	834.28	1102.71

36	up	4,046	1,113.63	3,816	525.44	1091.53
37	GPs	2,227	612.97	1,526	210.12	1059.03
38	problem	2,827	778.11	2,293	315.73	1028.34
39	available	4,634	1,275.48	4,755	654.73	1022.93
40	being	3,197	879.95	2,788	383.89	1015.75
41	medication	1,585	436.26	865	119.1	1001.83
42	may	5,880	1,618.43	6,657	916.62	985.69
43	"	3,536	973.26	3,344	460.44	948.14
44	before	1,562	429.93	885	121.86	946.7
45	was	10,017	2,757.11	13,266	1,826.63	944.94
46	demand	2,105	579.39	1,502	206.81	943.49
47	access	3,325	915.18	3,072	422.99	938.19
48	receptionist	1,941	534.25	1,318	181.48	934.93
49	their	7,856	2,162.31	9,873	1,359.44	919.62
50	than	3,533	972.43	3,392	467.05	915.6

Appendix 2: Top 30 collocates of 'unfortunately'

No.	Word	Total no. in this subcorpus	Expected collocate frequency	Observed collocate frequency	In no. of texts	Mutual information
1	unavoidable	93	0.457	6	6	3.713
2	human	84	0.413	5	5	3.597
3	due	2,583	12.703	124	121	3.287
4	unforeseen	115	0.566	5	5	3.144
5	unable	2,051	10.087	88	88	3.125
6	tend	117	0.575	5	5	3.119
7	delays	581	2.857	24	23	3.07
8	occur	236	1.161	9	9	2.955
9	none	144	0.708	5	5	2.82
10	occasionally	264	1.298	9	9	2.793
11	sometimes	1,565	7.697	52	52	2.756
12	failed	303	1.49	10	9	2.746
13	does	2,376	11.685	71	71	2.603
14	but	9,163	45.064	273	267	2.599
15	without	1,811	8.907	51	51	2.518
16	peak	255	1.254	7	7	2.481
17	led	223	1.097	6	6	2.452
18	occasions	563	2.769	15	15	2.438
19	seems	345	1.697	9	9	2.407
20	knowing	348	1.712	9	9	2.395
21	appears	317	1.559	8	8	2.359
22	common	241	1.185	6	6	2.34
23	session	255	1.254	6	6	2.258
24	occasion	896	4.407	20	20	2.182
25	sooner	225	1.107	5	5	2.176
26	there	7,238	35.597	158	157	2.15
27	today	511	2.513	11	11	2.13
28	funding	430	2.115	9	9	2.089
29	no	2,839	13.962	59	59	2.079
30	administrative	245	1.205	5	5	2.053

Appendix 3: Top 30 keywords from the 'new' subcorpus

		'new' subcorpus		Reference corpus			
No.	Keyword	Frequency (absolute)	Frequency (per mill.)	Frequency (absolute)	Frequency (per mill.)	Log ratio	Log-likelihood
1	brand	41	58.94	13	4.89	3.59	75.45
2	installing	31	44.56	12	4.51	3.3	52.21
3	installed	160	230	64	24.06	3.26	265.24
4	teething	54	77.62	22	8.27	3.23	88.7
5	appointed	83	119.31	40	15.04	2.99	124.62
6	employing	32	46	16	6.02	2.93	47.03
7	QEII	25	35.94	13	4.89	2.88	35.89
8	buildings	26	37.37	14	5.26	2.83	36.53
9	transition	33	47.44	20	7.52	2.66	42.89
10	recruited	125	179.68	76	28.58	2.65	162.11
11	existing	102	146.62	67	25.19	2.54	125.14
12	accepting	44	63.25	31	11.66	2.44	51.16
13	built	61	87.69	46	17.3	2.34	67.11
14	relatively	45	64.69	34	12.78	2.34	49.43
15	recruiting	126	181.12	100	37.6	2.27	132.68
16	registrations	57	81.94	47	17.67	2.21	58
17	cope	51	73.31	44	16.54	2.15	49.76
18	joining	90	129.37	78	29.33	2.14	87.43
19	recruit	102	146.62	90	33.84	2.12	97.39
20	premises	176	253	163	61.29	2.05	160.16
21	moving	114	163.87	116	43.62	1.91	93.82
22	salaried	50	71.87	51	19.18	1.91	41.04
23	starting	82	117.87	85	31.96	1.88	66.09
24	registering	123	176.81	129	48.5	1.87	97.82
25	BT	46	66.12	49	18.42	1.84	35.92
26	old	142	204.12	157	59.03	1.79	106.07
27	introducing	56	80.5	63	23.69	1.76	40.94
28	software	50	71.87	57	21.43	1.75	35.96
29	increasing	159	228.56	182	68.43	1.74	113.77
30	recruitment	66	94.87	77	28.95	1.71	46.08

Appendix 4: Top 30 keywords from the 'demand' subcorpus

No.	Keyword	'demand' subcorpus		Reference corpus		Log ratio	Log-likelihood
		Frequency (absolute)	Frequency (per mill.)	Frequency (absolute)	Frequency (per mill.)		
1	exceeds	39	98.68	9	3.38	4.87	115.68
2	ageing	17	43.01	4	1.5	4.84	50.19
3	rising	40	101.21	11	4.14	4.61	113.47
4	surge	18	45.55	5	1.88	4.6	50.92
5	cope	104	263.15	44	16.54	3.99	257.45
6	grow	21	53.14	9	3.38	3.97	51.74
7	unprecedented	53	134.11	24	9.02	3.89	127.88
8	risen	15	37.95	7	2.63	3.85	35.77
9	increasing	304	769.21	182	68.43	3.49	651.21
10	investment	24	60.73	17	6.39	3.25	47.24
11	increases	27	68.32	20	7.52	3.18	51.87
12	falling	19	48.08	15	5.64	3.09	35.21
13	growing	49	123.98	39	14.66	3.08	90.37
14	struggling	59	149.29	51	19.18	2.96	103.54
15	increased	293	741.37	281	105.65	2.81	480.92
16	capacity	217	549.07	220	82.72	2.73	342.8
17	increase	238	602.21	243	91.37	2.72	374.11
18	resource	44	111.33	47	17.67	2.66	66.94
19	finite	25	63.26	28	10.53	2.59	36.71
20	match	41	103.74	48	18.05	2.52	58.17
21	facing	58	146.76	70	26.32	2.48	80.31
22	supply	91	230.26	112	42.11	2.45	124
23	nationally	68	172.06	84	31.58	2.45	92.38
24	winter	43	108.8	58	21.81	2.32	54.17
25	recruited	56	141.7	76	28.58	2.31	70.16
26	higher	45	113.86	66	24.82	2.2	52.46
27	funding	142	359.3	214	80.46	2.16	161.26
28	resources	200	506.06	319	119.94	2.08	214.51
29	challenges	38	96.15	62	23.31	2.04	39.79
30	huge	63	159.41	108	40.61	1.97	62.53

Appendix 5: Top 50 keywords for mixed replies

No.	Keyword	Mixed replies		Reference corpus		Log ratio	Log-likelihood
		Frequency (absolute)	Frequency (per mill.)	Frequency (absolute)	Frequency (per mill.)		
1	tweet	25	15.82	3	0.56	4.81	56.22
2	champion	32	20.25	7	1.31	3.95	61.31
3	e-mailing	54	34.17	15	2.82	3.6	94.8
4	uplifting	41	25.94	13	2.44	3.41	68.07
5	recovering	465	294.22	154	28.92	3.35	756.99
6	expression	25	15.82	10	1.88	3.07	37.05
7	circulate	26	16.45	11	2.07	2.99	37.36
8	aunt	30	18.98	14	2.63	2.85	40.71
9	congratulations	153	96.81	74	13.9	2.8	203.09
10	glowing	74	46.82	36	6.76	2.79	97.86
11	impressed	109	68.97	54	10.14	2.77	142.5
12	consumer	33	20.88	17	3.19	2.71	42.06
13	speedy	255	161.35	132	24.79	2.7	323.96
14	reassuring	214	135.4	127	23.85	2.51	246.87
15	recovery	977	618.18	626	117.56	2.39	1062.31
16	urology	131	82.89	85	15.96	2.38	140.96
17	recover	60	37.96	39	7.32	2.37	64.47
18	infirmary	166	105.03	108	20.28	2.37	178.24
19	logistics	36	22.78	24	4.51	2.34	37.89
20	recovered	136	86.05	91	17.09	2.33	142.69
21	deliveries	64	40.49	43	8.08	2.33	66.92
22	relations	274	173.37	186	34.93	2.31	284.03
23	rheumatology	48	30.37	33	6.2	2.29	49.22
24	circulated	83	52.52	59	11.08	2.24	82.68
25	thrilled	76	48.09	56	10.52	2.19	73.3
26	pleasing	259	163.88	195	36.62	2.16	244.9
27	brother	45	28.47	34	6.38	2.16	42.41
28	cardiology	145	91.75	112	21.03	2.12	133.83
29	wonderful	317	200.58	245	46.01	2.12	292.43
30	compliment	203	128.44	161	30.23	2.09	182.63
31	delighted	1,513	957.32	1,240	232.86	2.04	1317.97
32	condolences	78	49.35	64	12.02	2.04	67.83
33	dad	39	24.68	32	6.01	2.04	33.92
34	hello	458	289.79	379	71.17	2.03	394.93
35	endoscopy	92	58.21	77	14.46	2.01	78.4
36	words	1,455	920.62	1,236	232.11	1.99	1221.45
37	complimentary	51	32.27	44	8.26	1.97	42.1

38	mum	117	74.03	101	18.97	1.96	96.52
39	nice	586	370.78	510	95.77	1.95	479.31
40	forwarded	379	239.8	330	61.97	1.95	309.82
41	fantastic	137	86.68	122	22.91	1.92	109.28
42	father	309	195.51	286	53.71	1.86	236.03
43	'll	400	253.09	371	69.67	1.86	304.82
44	birth	276	174.63	257	48.26	1.86	209.37
45	co-ordinator	70	44.29	66	12.39	1.84	52.33
46	radiology	59	37.33	56	10.52	1.83	43.77
47	reviewer	132	83.52	126	23.66	1.82	97.27
48	bits	52	32.9	50	9.39	1.81	37.99
49	professionalism	88	55.68	87	16.34	1.77	62.16
50	appreciation	312	197.41	309	58.03	1.77	219.92

Appendix 6: Top 20 keywords of mixed replies in response to positive Hospital comments

No.	Keyword	Mixed replies (positive, Hospital)		Reference corpus		Log ratio	Log-likelihood
		Frequency (absolute)	Frequency (per mill.)	Frequency (absolute)	Frequency (per mill.)		
1	glowing	57	131.09	9	17.83	2.88	46.44
2	hello	209	480.65	51	101.06	2.25	128.03
3	recovering	377	867	93	184.28	2.23	228.98
4	impressed	78	179.38	21	41.61	2.11	43.97
5	five	63	144.88	18	35.67	2.02	33.63
6	reassuring	145	333.46	44	87.19	1.94	73
7	wishing	99	227.67	32	63.41	1.84	46.66
8	ease	117	269.07	38	75.3	1.84	54.85
9	hi	137	315.06	45	89.17	1.82	63.44
10	looked	199	457.65	66	130.78	1.81	91.18
11	speedy	199	457.65	69	136.72	1.74	86.67
12	congratulations	126	289.77	44	87.19	1.73	54.42
13	recovered	100	229.97	35	69.35	1.73	43.07
14	professional	149	342.66	55	108.98	1.65	60.14
15	wife	119	273.67	44	87.19	1.65	47.93
16	shall	97	223.08	36	71.33	1.64	38.88
17	management	102	234.57	38	75.3	1.64	40.69
18	sincerely	172	395.56	65	128.8	1.62	67.37
19	friendly	110	252.97	42	83.22	1.6	42.5
20	pleasing	144	331.16	57	112.95	1.55	53.01