Lancaster University

Department of Linguistics and English Language

The Dynamics of Nurse-Patient Interaction:

A Comparison of Spoken Interaction with Older and Younger Patients

Michaela Lunan

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ABSTRACT

The NHS is currently supporting a patient-centred approach to healthcare, but have identified a number of communication issues. Campaigns within the UK have highlighted that even basic steps of communication are lacking and can lead to patients feeling disempowered and dehumanised. For example, it is commonly assumed or indeed claimed that nurses use patronising language with older patients (e.g. Brown & Draper, 2003), but a lack of empirical data comparing the language used with younger and older patients and a need for studies to acknowledge the patients' perceptions (Shattell, 2004) challenge this supposition.

This study discovers the nature of social interactions between nurses and their patients in two GP practices in the Northwest of England. It provides an in-depth account through the use of rich primary data sets. One is a corpus of 100 audio interactions recorded with 10 nurses. Each nurse was recorded with 5 older patients and 5 younger patients in order to draw comparisons in language use. The other consists of 97 interviews reporting nurse and patient perceptions, and thereby allowing us to fill a gap in previous research.

Taking an interpersonal pragmatic approach, deploying concepts such as politeness (e.g. Leech 2014), humour (Norrick, 2009), face and mitigation (Brown & Levinson, 1987), the thesis reveals, amongst other things, the differences between how nurses talk to younger patients and older patients, considers how the patients perceive the nurses' discourse, and examines individual interpersonal practices. An analysis of the openings and closings of the interaction in the first analysis chapter led to the identification of the typical structures of these phases, which differ in form to that of doctor-patient consultations. Greetings, which are typically seen as adjacency pairs (Schegloff & Sacks, 1973), were often not responded to and small talk or phatic communication was usually limited to a small number of turns. The second analysis chapter focusses on requests in the interaction, as patronising talk has been purported to occur largely in requests by nurses (Herman & Williams, 2009a). Analysis of these turns found that there was very little evidence of patronising behaviour, especially when the perceptions of the patients were taken

into account. This could be due to a more positive view of the older patients that attend GP surgeries as they may be more independent than patients in care homes. The final analysis chapter shows that patients and nurses both use a large amount of humour but do not always respond to humour in the same way.

TABLE OF CONTENTS

LIST OF FIGURES

LIST OF TABLES

LIST OF ABBREVIATIONS

P – patient, when followed by a number this corresponds to the transcript number and ranges from 1-100.

N – nurse, when followed by a number this corresponds to the nurse's number and ranges from 1-10.

NHS – British National Health Service

GP – General Practice

CI – Chief Investigator

FTA – Face threatening act

B&L – Brown and Levinson's (1987) theory of politeness

S - Speaker

H - Hearer

A - Act

NSB – Never seen before patient

HAY – 'How are you' sequence

FET – Fischer Exact Test for statistical significance

CHAPTER 1

1. INTRODUCTION TO THE THESIS

1.1. Introduction

Recent issues within the National Healthcare System (NHS) stipulate that communication between healthcare workers and their patients needs to be improved (Mid-Staffordshire (Francis, 2013), Winterbourne View (Bubb, 2014)). The NHS has introduced various plans of action, such as the 6 C's (2012) and 'No decision about me without me' (2012), which aim to improve patient-centred communication by promoting compassion, empathy, care and dignity. Further to these issues, health professionals are reported to use patronising and infantilising talk with older patients (Caporael, 1981; Makoni & Grainger, 2002) which can leave patients feeling disempowered and dehumanised. Despite these claims, there has been no research comparing the ways in which healthcare professionals talk to younger and older patients. This PhD applies a third-wave linguistic politeness framework to transcripts of dialogues between 10 nurses and 50 younger patients (aged 18-45) and 50 older patients (aged 65+) triangulated with 97 post-consultation interviews with the patients in order to gain an understanding of their perceptions of the interactions. The study analyses how openings and closings, requests and humour work in these consultations and determines whether there are differences in nurse's communication with older versus younger patients within this setting.

1.2. Rationale for the Study

The key rationales for this study are listed below:

1. Communication between healthcare professionals and their patients needs to be improved. The NHS has stated that communication issues contributed to the Mid- Staffordshire (Francis, 2013) and Winterbourne View (2012) crises[1]. A

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[1] The Mid-Staffordshire crisis involved the deaths of between 400 and 1,200 patients as a result of poor care at Stafford hospital between 2005 and 2009. The Winterbourne View crisis involved the abuse of patients at residential care home near Bristol.

positive nurse-patient relationship is vital in order to provide quality nursing care and the use of language in consultations has a profound impact on this relationship (Silverman et al., 2005). Linguistic politeness theory is relevant to nursing communication as both nurses and patients can potentially have different wants and needs from a consultation. Both parties can express compassion and care by using linguistically 'polite' phrases and the use of politeness features by both interactants can influence whether the consultation is a positive or negative experience for both parties.

2. The proportion of older people is increasing in the UK. In 2010 there were 10 million people aged 65 and over, by 2020 there will be a further 5.5 million (Cracknell, 2010). In 2016 18% of the UK population was aged 65 and over, a 3.8% increase of the proportion in 1976 (Randall, 2017). The NHS recognises that it does not appropriately cater for its majority care user - older patients, by not meeting their individual needs, both practical and social. This is supported by a number of studies, which claim that healthcare workers use baby-talk and patronising language with older patients (e.g. Backhaus, 2009). However, these studies have only analysed language in interactions between caregivers and older patients; no research has produced data on interactions which are directly comparable with that of younger patients.

3. Studies that focus on healthcare professionals' language mainly focus on doctor-patient interactions rather than nurses; despite the fact that 'the nurse's role permeates the entire range of patients' experience with the clinic'. (Poulton, 1996, p. 26). This belief is furthered by Iedema (2005), Mullany (2009) and Sarangi (2005), who all argue that healthcare communication studies should cover a variety of professional roles rather than simply focus on doctors alone.

4. Previous studies on healthcare communication with a focus on politeness have an emphasis on the care givers' utterances as separable bits for analysis, rather than analysing the interaction as a whole and taking into account the understandings of both the patient and the care giver. Previously patients' considerations and utterances have been ignored, creating an urgent need for

research in the area (Shattell, 2004).

5. A further issue of previous healthcare communication studies has been the lack of empirical data. As noted by Locher and Schnurr (2017) research in this field tends to use hypothetical scenarios and questionnaire data (e.g. Bartlett & Coulson, 2011; Haughan et al., 2013; McCabe, 2004; Pitts et al., 2014; van der Cingel, 2011). However, naturally-occurring data is integral to gaining an understanding of the discourse practices in healthcare settings and this thesis will add to the recently growing collection of studies that use this form of data (Backhaus, 2009; Grainger, 2004b; Marsden & Holmes, 2014).

6. The PhD will add to research on institutional discourse via the use of linguistic politeness strategies (Holmes, 2000, 2006; Mullany, 2008; Schnurr et al., 2008). As such, it will attempt to build upon our current understandings of what constitutes polite behaviour within this particular healthcare setting and how this behaviour relates to institutional norms (a need identified by Bargiela-Chiappini and Harris (2006, p. 27)).

7. This thesis presents an opportunity for testing the efficacy of interpersonal pragmatics theories and frameworks, especially in relation to openings/closings, requests and humour within the setting of GP practices via the use of naturally occurring data.

1.3. **Aims and Objectives**

This thesis aims to cast light on the nature of social interaction between nurses and patients. More specifically, it will answer the following questions:

- Is there a difference between how nurses talk to younger patients and older patients and, if so, what is the difference?
- If patronising talk occurs, how does it work in this context?
- How are the socially sensitive moments of talk managed? More specifically, how do openings and closings, requests and humour work?

- Do nurses have individual interpersonal practices, and if so, how do they differ?

Overall, this study has the potential to open up and improve professional carers' understandings of working with patients and, in an ever-growing aging population, offer a chance to improve the experience for both participants.

1.4. **Methodologies**

The thesis analyses 100 audio-recorded interactions with 10 nurses from two GP surgeries in the North West of England. The nurses were each recorded with five older patients (aged 65+) and five younger patients (aged 18-45) in order to uncover potential differences in the language used in consultations with older and younger patients. Following from the recorded consultation the researcher interviewed the patients to ascertain their evaluations of the interaction.

NHS Research Ethics Committee Approvals and local governance permissions were obtained, and patients were approached by the surgery upon making a future appointment as to whether they would like to take part in the study. Upon patient approval the researcher accompanied them to their consultation and audio-recorded the interaction, whilst taking notes of non-verbal behaviour.

Recorded consultations included taking blood, diabetic and asthma reviews, vitamin B12 injections, contraception advice, ECGs, wound dressings and general health queries. These appointments covered a large range of duties carried out by nurses within the GP setting and allowed for trends of behaviours to be identified.

The corpus of data was analysed using an interpersonal pragmatic approach that includes concepts such as politeness (Brown and Levinson 1987), frames (Bateson 1972), face (Goffman, 1967) and mitigation in order to gain an understanding of polite and appropriate behaviour in this institutional setting. The traditional politeness approach of Brown and Levinson (1987) was adapted to extend the

analysis beyond the utterance, looking at extended discourse in use that involved negotiation and understandings from both participants. My approach enhanced Brown and Levinson by considering a number of additional contextual factors in order to interpret communicative behaviours and uncover potential institutional norms (similar to the approach of Holmes and Marra, 2014).

Quantitative and qualitative approaches were applied to the data. This approach combined both inductive and deductive modes of analysis through the use of the pragmatic theories. These pragmatic theories accounted for observations and then they were assessed through the amount of usage in the data. This analysis was further triangulated by the post-consultation interviews allowing for patient perspectives of communication to help build an understanding of how nurse-patient consultations work in a GP setting and what communicative behaviours are positively evaluated.

1.5. Structure of the Thesis

Following this introductory chapter, a literature review will be provided. The literature review is divided into three separate chapters. Chapter 2 includes an introduction to interpersonal pragmatics and politeness, whilst also discussing the analytical approach that this thesis will adopt. It reviews a number of traditional theories from pragmatics, provides summaries of a number of politeness approaches and argues the reasons for adopting a newer approach to the study of my data. Chapter 3 discusses relevant healthcare literature and is divided into sections covering current NHS issues, patient-centred and task-centred communication, power and, finally, dignity in healthcare interactions, which covers the definition and review of the literature analysing patronising talk.

Chapter 4 refers to literature that directly corresponds to the analysis chapters within this thesis. An initial analysis of 12 interactions uncovered areas of particular note within the interactions: openings and closings, task-related talk that included a large number of requests, and an unexpectedly frequent use of humour and social talk.

Chapter 4 reviews both linguistic and healthcare literature that relates to these features.

The methodology is discussed in chapter 5, supporting the one that was chosen and also reviewing other potential methods. Ethical considerations are listed in the section as well as participant inclusion and exclusion criteria. The methods of data analysis conclude that chapter.

Chapters 6, 7 and 8 include the analysis of the corpus of data. The first findings chapter provides common features within the opening and closing phases of nurse-patient interactions. The openings of the interactions reveal a lack of nurse introductions and 'how are you' questions, with few patients responding to greetings, suggesting a task-centred approach by both interactants. The analysis of closings uncovers the complexity of closing interactions within this setting. The second findings chapter looks at the usage of requests by nurses, as patronising features have been reported to occur in and around these speech acts (e.g. Brown & Draper, 2003; Makoni & Granger, 2002). The analysis of these potentially patronising features found that they were not perceived as such by the patients and were evident in interactions with both younger and older patients. Finally, chapter 8 analyses the use of humour by both nurses and patients and reveals that humour seems to play a large role in building relationships between patients and nurses.

Chapter 9 provides a summary of my findings, notes implications for both the healthcare and linguistic fields, notes potential limitations and suggests areas for further research.

CHAPTER 2

2. INTERPERSONAL PRAGMATICS

2.1. Introduction

Pragmatics in a linguistic setting is seen as the 'contribution of context to language understanding' (Levinson, 1983, p. 31) and 'takes into account the complexity of [the language's] cognitive, social, and cultural (i.e. meaningful) functioning in the lives of human beings' (Verschueren, 2009, p. 19). Interpersonal pragmatics (Locher & Graham, 2010) is focussed on the study of (im)politeness, which will be discussed in more detail in section 2.3, but can be briefly defined as 'the means by which relationships are negotiated and contested/disrupted' (Haugh et al., 2013, p. 1). Despite being focussed on (im)politeness research, interpersonal pragmatics is not limited to this field but is an 'interdisciplinary enterprise' (ibid. p. 11) that can draw upon other disciplines to gain a better understanding of different practices and what is occurring at the interpersonal level.

This chapter outlines the approach taken in this thesis by first, briefly discussing two theories that are commonly seen as synonymous with pragmatics: speech act theory (Austin, 1962) and the cooperative principle (Grice, 1975) in sections 2.2.1 and 2.2.2, respectively. The chapter then moves to a short breakdown of the three waves of politeness research, including the chosen theory for this thesis – neo-politeness theory (section 2.3). This theory largely involves the categories used by Brown and Levinson's (1987) framework (see section 2.3.1.1), but also involves additions that are outlined in section 2.3.4.1. A brief conclusion finalises the chapter in section 2.4.

2.2. Fundamental Pragmatic Theories

2.2.1. *Speech Act Theory*

Austin (1962) attempted to bridge the gap between language and reality in a pragmatic review of how words can have an impact on the extra-linguistic world around us, and thereby developed speech act theory. This theory underpins the most

frequently referenced face-based theory of politeness by Brown and Levinson (1987), therefore it is central to a number of studies on politeness and requires definition and discussion within this study.

Speech act theory suggests that 'the minimal units of human communication are...the performance of certain kinds of acts, such as making statements, asking questions etc.' (Blum-Kulka et al., 1989a, p. 2). Austin (1962) argued that we do not simply use language to state what is true or false, as previously believed, but we use words, whether written or uttered, to perform an action. For example, a speaker may say, 'I promise I will give you the money on Thursday', and in doing so his/her words have a performative effect. Austin refers to verbs such as 'promise', 'bet' and 'declare' as performatives. A performative verb is not always necessary for an utterance to have a performative effect, for example, one can make a promise with the statement 'You'll get the money on Thursday'.

In order for a speech act to have its intended performative effect the circumstances, such as setting and the speakers' relation to one another, need to be appropriate. Austin refers to these dependencies as 'felicity conditions', and Searle (1969) created 'constitutive' rules to help define how particular types of speech acts are constituted:

1. Propositional Content Condition – focuses on propositional content
2. Preparatory Condition – gives the circumstances for the speech act's successful performance.
3. Sincerity Condition – denotes whether the speech act is taken or intended sincerely.
4. Essential Condition – determine the illocutionary act (stating, commanding etc.)

It is expected that requests will be used throughout consultations between nurses and their patients. Therefore, the felicity conditions of a request are given as an example:

Propositional content: Future act (A) of Hearer (H)
Preparatory conditions: 1. H is able to do A. Speaker (S) believes H is able to

do A.

2. It is not obvious to both S and H that H will do A in the normal course of events of his own accord.

Sincerity condition: S wants H to do A.

Essential condition: Counts as an attempt to get H to do A.

(Searle 1969, p. 66)

Speech acts can be direct (through linguistically expressing what the speaker means) or indirect (where the meaning must be inferred by the hearer). Searle (1975) defines indirect speech acts as 'cases in which one illocutionary act is performed indirectly by way of another' (p.60). He states that some indirect speech forms are conventionally used for certain acts. For example, in 'Can you pass the salt?' the modal 'can' and the interrogative form literally questions the hearers' ability, but the speaker here is actually making a request to be handed the salt. Searle defines this form as conventionally indirect, as it orientates to a felicity condition of the request (i.e. the preparatory condition of ability). Indirectness is important here as it underpins the classic politeness model of Brown and Levinson (1987).

There have been a number of critiques of the 'founders' of speech act theory. Firstly, Burkhardt (1990) argues that Austin's theory is 'a purely pragmatic approach whereas Searle's conception is a hybrid between semantics and pragmatics' (p. 92). Secondly, it has been argued that Searle's conditions do not clarify overlapping speech acts. For example, a compliment and congratulations only differ via the essential condition, but are somewhat unrelated speech acts (Thomas, 2014). Thirdly, some utterances can have a number of functions and are difficult to label as just one speech act. Finally, Searle himself recognises that he 'deals with a simple and idealized case' (1969, p. 55) resulting in his methodological approach being restricted. For further elaboration on the problems and limitations of speech act theory, see Culpeper and Haugh (2014).

2.2.2. *Cooperative Principle*

Politeness theory is grounded in the co-operative principle as it is argued that speakers may break the associated maxims in order to be polite. The theory of Leech (1983) actually builds upon Grice 's (1975) Co-operative Principle and formulates politeness maxims. Somewhat similar to Searle's idea of indirectness, Grice posited the theory that speakers imply meanings by breaking rational principles of quantity, quality, manner and relation in their utterances (known as maxims). Grice states that interlocutors tend to:

> Make [their] conversational contribution such as is required, at the
> stage at which it occurs, by the accepted purpose or direction of the
> talk exchange in which [they] are engaged. (1975, p. 45)

A summary of the maxims can be found below (detailed in full in Grice (1975, p. 51)):

1. Quantity: The speaker should be as concise as possible whilst providing the correct amount of information that is required.
2. Quality: The speaker should speak only what they believe to be true and have sufficient evidence to support.
3. Manner: The speaker should only say what is easily understood to avoid ambiguity and obscurity. Their utterances should be structured and to the point.
4. Relation: The speaker should make their utterances relevant to the conversation at hand.

There are various ways in which a speaker may fail to follow these maxims, according to Grice (1975).

1. Violate a maxim: The speaker may subtly break a maxim with the purpose to mislead.
2. Opt out of a maxim: The speaker may indicate that he/she is unwilling to cooperate in the way the maxim requires.
3. A clash of maxims: One maxim may be chosen to be followed in preference of another if both cannot be followed.

4. Flout a maxim: The speaker may obviously and blatantly break the maxim. This often leads to the hearer inferring an implicit meaning from the utterance, resulting in 'conversational implicature'.

By flouting a maxim it is argued that the hearer is aware of the maxim not being followed and infers meaning from it. Also, the speaker expects the hearer to interpret the utterance as such. Grice therefore claims that there is 'a relationship between the conventional meaning of an utterance and any implicit meaning it might have, and that it is calculable' (Davies, 2007, p. 2310) .

2.3. **Approaches to Politeness**

As this study has a special focus on the usage of politeness by nurses and their patients, it is important to provide a review of politeness research and the language and behaviour that is considered to be polite. However, despite the large array of linguistic politeness studies, 'the field still lacks an agreed definition of what "politeness" is' (Bargiela-Chiappini, 2003, p. 1464), this still holds true today. This section will briefly outline the three waves of politeness research, whilst also discussing and defending the adopted approach, i.e. neo-politeness (Holmes, 2012) .

The study of politeness has generally come about in three waves (Culpeper, 2011b; Grainger, 2011) . The three approaches can be distinguished by two scales according to Haugh and Culpeper (2018). The first is a scale of the extent of which the theory attempts to develop an 'account of (im)politeness based on social versus pragmatic theories of language-in-use' (ibid. p. 4) while the second positions the theory based on user (first order) versus observer (second order) understandings of politeness.

2.3.1. *First-wave Approaches*

The first wave of politeness research occurred during the 1970's and 1980's, and was made up of the now traditional models of politeness, including the works of

Brown and Levinson (1987), Lakoff (1973) and Leech (1983). Those first wave approaches were grounded in the aforementioned pragmatic theories of Searle, Austin and Grice. These theories of politeness generally saw politeness as a mechanism for maintaining social harmony. For example, Brown and Levinson defined politeness as a way of disarming the potential for aggression and allowing for potentially aggressive parties to communicate (1987, p. 1). Lakoff likewise saw it as a means of 'minimising confrontation in discourse – both the possibility of confrontation occurring at all, and the possibility that a confrontation will be perceived as threatening' (1989, p.12). On a somewhat different note, Leech saw politeness as speaking or behaving 'in such a way as to (appear to) give benefit or value not to yourself but to the other person(s), especially the person(s) you are conversing with' (2014, p. 3). I would argue that although minimising confrontation is most certainly the case for some usages of politeness, it can also be used simply to make a hearer feel more comfortable or to build solidarity and rapport, in other words, without an orientation to confrontation. I expect these features to be key in the usage of politeness by the nurses to their patients.

Similar to Lakoff's rules of politeness (1973), Leech's framework is heavily grounded in Grice's cooperative principle (1983) and uses a maxim-based approach to explain how and why people create meaning and, within that, politeness. Brown and Levinson (1987), discussed in more detail below, provide an allegedly universal theory of facework that looks at how speech acts can be mitigated through strategies of politeness. These theories focus on the speakers' intentions via conversational implicature, but largely ignore the hearers' perspectives and understandings.

2.3.1.1. *Brown and Levinson*

Despite the criticisms of Brown and Levinson's theory of facework (e.g. Eelen, 2001), it is still the most influential and comprehensive politeness framework that has proved itself useful in a vast number of studies by describing polite linguistic behaviours and accounting for the reasons behind these behaviours according to face (defined below). It is for this reason that Brown and Levinson's framework will be applied in this study.

Brown and Levinson's notion of face, derived from Goffman (1967), is a 'public-self image' (1987, p. 61) that is managed and enhanced via interaction, which they believe is done through the use of politeness. Brown and Levinson argue that, as a person's 'face' is vulnerable, interactants will cooperate with one another to maintain face and act in a way that assures they heed these social expectations.

'Face' is divided into two; a person's positive face refers to their 'desire to be approved of' while negative face is 'the desire to be un-impeded in one's actions' (ibid. p. 13). These faces can then be heightened or threatened through speech acts referred to as 'face threatening acts' (FTAs). One can threaten someone's positive face by complaining or criticising him/her or one can threaten their negative face through ordering or requesting things from them.

Politeness in Brown and Levinson's terms is a system of counterbalancing these acts via a number of politeness strategies. In using these strategies the speaker is able to make their positive views and negative wants known, whilst at the same time communicating that they are being polite and considering the hearer's face. A summary of these strategies is shown below:

Circumstances determing choice of strategy:
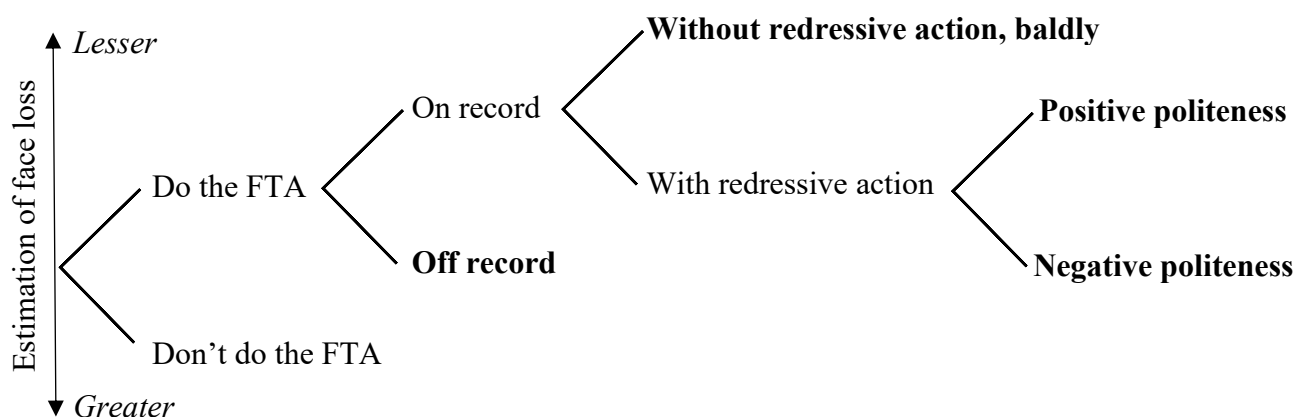
Brown & Levinson, 1987, pp. 60, 69

Figure 1: Brown and Levinson's (1987) strategies of politeness

1. On record politeness is when a speaker makes the FTA in a bold and direct manner.
2. Positive politeness is when a speaker heightens the hearer's positive face wants through expressing interest in them, seeking agreement, assuming common ground etc.
3. Negative politeness is when a speaker heightens the hearer's negative face wants through apologising, giving deference, minimising the imposition through hedges and questions etc.
4. Off record politeness is closely linked to indirectness and consists of flouting Grice's conversational maxims to leave the speaker 'with a number of defensible interpretations' (ibid. p. 103).

In order to assess the severity of an FTA, and therefore choose which strategy to apply to counterbalance it, the speaker takes into account the following variables:

- Social distance – less politeness is needed if the interlocutors have a close relationship
- Relative power – larger amount of politeness is needed if the hearer's power is high
- Size of imposition – the more serious the imposition, the more politeness is needed.

These variables are then added together to deduce the risk of the face-threatening act and the speaker will then select a strategy that fits the circumstance and the pay-off of the FTA. An example would be a nurse telling a patient that they need a blood sample. The following quote was given via questionnaire in a study of GP surgery communication (Lunan 2010):

Nurse: *I just need to take a small amount of blood*

Here, according to Brown and Levinson, the social distance would be quite high as the interlocutors would not typically have a very close relationship; the nurse could be argued to have more power as she is a professional and the size of the imposition would be quite large as the act involves potential pain and discomfort for the patient. As seen in the quote, the nurse uses the

adverb and adjective 'just' and 'small' respectively, to minimise the imposition. This is an example of negative politeness in an attempt to satisfy the patient's negative face. The statement does not request permission, which could be due to the relative power of the nurse in the situation and could have resulted in less politeness being used.

This framework is applicable in medical discourse as Robins and Wolf argue that 'in therapeutic encounters…there are frequent opportunities for patients to interpret what their physicians say as threatening' (1988, p. 217). This would suggest that the patient's positive and negative face could be threatened in a GP practice and that the nurses may use varying strategies to lessen these face threats.

Although Brown and Levinson's framework is widely used it has also received various criticisms. One major criticism is that politeness can occur 'through multiple aspects of language use' (Spencer-Oatey, 2008, p. 20), not just speech acts. Spencer-Oatey argues that there are various domains that play important roles in politeness; the discourse domain, the participation domain, the stylistic domain and the non-verbal domain. In my analysis I will be looking at other aspects of politeness than just speech acts as all use of language could be deemed as potentially face threatening.

A further issue is that Brown and Levinson's theory involves focussing on an academic conceptualisation of politeness phenomena rather than considering potential culture-specific and lay understandings that the speaker may have of their utterance. Eelen (2001) argues that Brown and Levinson's theory posits the ordinary speaker as sharing the scientist's perspective and notion of politeness and therefore applies a framework in interaction (p. 82), which Eelen deems as unrealistic. My study takes lay understandings into consideration as post-consultation interviews with the interactants took place. Kádár and Haugh (2013) also point out that Brown and Levinson's ideas of 'face and rationality…reflect specific understandings of the human psyche which do not apply in every culture and society' (p. 20), arguing against their universal theory. This issue is furthered and exemplified by the research of Mao (1994), Ide (1989) and Gu (1990).

Lakoff (1989) and Kasper (1990) believe theories of politeness should also consider impoliteness and define the phenomena as a scale covering both terms. Throughout Brown and Levinson's book the term impoliteness is ignored and Eelen views this as negligent. He argues the phenomena are 'two sides of the same coin' (2001, p. 92) and that any politeness theory needs to deal with the two terms in conjunction. However, Brown and Levinson only ever claimed to provide a theory of politeness and this criticism goes beyond the scope of their research.

Locher and Watts state that Brown and Levinson's framework does not address politeness but merely facework, as it deals 'only with the mitigation of face threatening acts' (2005, p. 10). This is true as Brown and Levinson's framework does only deal with the view of politeness as a method of disarming potential aggression and face threats. It does not encompass pos-politeness - behaviour that grants the addressee positive value (Leech, 2014), such as wishing a neighbour 'good morning' or paying them a compliment. Therefore, I will use this term throughout when this form of language appears in my data.

A final criticism, which is extremely pertinent, is that Brown and Levinson inadequately handle context, reducing it to 'a handful of social variables (power and social distance) which do not reflect the complexity of real world interactive events' (Culpeper, 2011b). This will be dealt with by using the notion of frames and social conventions (Spencer-Oatey, 2005; Terkourafi, 2005), discussed in the following sections.

2.3.2. *Second-wave Approaches*

The second wave approaches of politeness theory, in critical opposition to the traditional models, focuses on emergent meanings within interaction rather than providing a predictive theory. It 'tries to offer ways of recognising *when* a linguistic utterance *might* be open to interpretation by interlocutors as "(im)polite"' (Leech, 2014, p. 90). The approach emphasises the importance of context and rather than suggesting that (im)politeness is 'inherent in particular forms of language..[it argues instead] that it is a matter of the participants' evaluations of particular forms as

(im)polite in context' (Culpeper & Haugh, 2014). The participants' evaluations are key as the discursive approach distinguishes between first-order and second-order politeness. First order politeness pertains to 'common sense notions of politeness' (Watts et al. 1992, p. 3) or a layperson's understanding of the term, such as saying 'thank you' when getting off a bus in Britain. By contrast second order politeness covers theoretical understandings such as those of Brown and Levinson and Leech. Discursive approaches take a preference for the former so as not to privilege the analyst's perspective. However, this approach leads to problems as by rejecting the idea that there are conventionalised usages of politeness, analyses become 'minute descriptions of individual encounters, but these do not in any way add up to explanatory theory of the phenomena under study' (Terkourafi 2005, p. 245), despite numerous studies uncovering linguistic patterns (Haugh & Culpeper, 2018). A purely discursive approach was dismissed in this study as in order to analyse my data conventional uses and discourse in situ will need to be analysed.

2.3.3. *Third-wave Approaches*

Finally, the third wave approaches are a kind of middle ground between the classic approaches and the discursive approaches and include various reformulations for the understanding of politeness and impoliteness, and some newer frameworks that can be applied to data (Spencer-Oatey, 2008; Terkourafi, 2005). The definition of politeness by Spencer-Oatey holds particular weight for this study:

> [I] take (im)politeness to be an umbrella term that covers all kinds of evaluative meanings (e.g., warm, friendly, considerate, respectful, deferential, incident, aggressive, rude). These meanings can have positive, negative or neutral connotations, and the judgements can impact upon people's perceptions of their social relations and the rapport or (dis)harmony that exists between them.
>
> (Spencer-Oatey, 2005, p. 97)

This definition covers both polite and impolite behaviour, whilst also considering the perceptions of the hearer (a feature which traditional theories tended to lack) and

also takes into account the effect this behaviour can have on social relations (a key aspect of my analysis). My analysis takes a broader understanding of what politeness entails – looking at humour, small talk and openings and closings of interactions rather than being restricted to the analysis of speech acts as per some traditional views.

The third wave approaches acknowledge the failings of the two previous waves to varying degrees, some seeing more weight in the user's perspectives, taking a social approach (e.g. Locher, 2012) and others preferring a more theoretical (observer-based), pragmatic approach (e.g. Terkourafi, 2005). However, all of the third wave approaches agree that 'we need to strike a balance between the perspectives of participants and analysts in theorising (im)politeness' (Haugh & Culpeper, 2018, p. 4). They also aim to encompass conventional forms of politeness (like traditional methods) and dynamic uses in situ (similar to discursive approaches).

The following figure shows the development of Haugh and Culpeper's (2018) scales that includes all three waves of politeness theories with a selection of politeness models placed in each. For a more detailed review of the theories mentioned, see Culpeper (2011b) and Haugh & Culpeper (2018).

Social ← → Pragmatic

User

Second wave *Third wave* *First wave*

| Discursive-materialist (Mills 2017) |

| Discursive approaches (e.g. Watts 2003, Eelen 2001) |

Socio-interactional (Haugh 2013, 2015)

Discursive-relational (Locher 2006, 2012)

Socio-pragmatic (Culpeper 2011, 2016)

Genre-based (Blitvich 2010, 2013)

Sociolinguistic (Holmes et al. 2011)

Frame-based (Terkourafi 2001, 2005)

Maxims-based (Leech 1983, 2007, 2014)

Facework theory (Brown & Levinson 1987)

Observer

Figure 2: A modified version of Haugh and Culpeper's (2018) scales of politeness theories

2.3.4. *The Adopted Approach: neo-politeness theory*

The third wave approach I will be adopting can be found in the centre of figure 2 - labelled by Haugh as the sociolinguistic approach, but referred to by Holmes as neo-politeness theory.

> Neo-politeness theory builds on the valuable analytical categories provided by Brown and Levinson's (1987) classic model, but extends the analysis beyond the utterance to encompass extended discourse and negotiated interaction, locating the analysis in specific social (workplace) contexts, and bringing contextual knowledge to bear in interpreting social meaning.
>
> (Holmes & Marra, 2014, p. 114)

Further to this, when using the framework on interaction between nurses and their patients, Grainger argues that 'the notion of 'politeness' in Brown and Levinson's technical sense remains a useful contribution to the analysis of verbal strategies that mediate human interactions' (2011, p. 184).

Neo-politeness theory builds on Brown and Levinson by taking into account the importance of context, specifically within the workplace. Due to the weight that the context will no doubt add to my data, it cannot be ignored, thereby making the traditional approach of Brown and Levinson insufficient as their approach only considers context in terms of a few variables (social distance and power) that do not adequately explain the complexity of context. Therefore, I will use the notion of frames (defined in Section 2.3.4.3) to help account for the context and draw from Spencer-Oatey's rights (section 2.3.4.1.1) as politeness does not simply revolve around face.

This approach also allows for the user's perspective to be considered as the post-consultation interviews with participants will provide lay understandings of perceived politeness within the interactions.

2.3.4.1. *Additions to Brown and Levinson*

2.3.4.1.1. *Rights and Reciprocity*

As previously stated, I will largely use Brown and Levinson's framework for its 'valuable analytical categories' (Holmes & Marra, 2014, p. 114), but will supplement it, where necessary, with other approaches. Spencer-Oatey's rapport management approach (2002) is an alternative to B&L's as it also builds upon Goffman's definition of face, but she sees B&L's positive face and negative face to be unrelated. Spencer-Oatey argues that positive face deals with face concerns whereas negative face deals with sociality rights – a term she defines as 'fundamental social entitlements that a person effectively claims for him/herself in his/her interactions with others' (2008, p. 14). Spencer-Oatey thereby distinguishes between face management and rapport management. Her framework further distinguishes between face and rights as detailed below:

- Face
    - Quality face – the desire to be evaluated positively (similar to B&L's positive face)
    - Relational face – the desire to be positively evaluated in relation to others, e.g. to be seen as a talented leader
    - Social identity face – the desire for others to 'acknowledge and uphold our social identities or roles' (2005) e.g. our religious group or nationality
- Sociality rights
    - Equity Rights – desire to be unimpeded in one's actions (similar to B&L's negative face)
    - Association Rights - belief that one is entitled to relations with others
                                                                (Spencer-Oatey, 2008)

A rather straightforward example of the nurse asking the patient to lift his jumper is given below in order to show how the two theories can work harmoniously with one another.

Extract 1: Transcript 60

> 1.N: right (.) I'll have a listen of your chest (1.6s) can you just bring your (.)
> sweater and your shirt up to your shoulders^ please^
> 2.P: can you do that for me^ (to W)
> 3.W: yes (.) stand up love ((P stands up and W begins taking off his jumper))

According to Brown and Levinson this request could threaten the patient's negative face (equity rights) by reducing his autonomy and, to an extent, his privacy as he is having to show his naked torso to not only the nurse, but the researcher present in the room as well – an act that many British people may feel uncomfortable with. This potential threat is mitigated via the use of both positive (please) and negative politeness strategies (minimisers and indirectness). However, Spencer-Oatey pays much more attention to context in her theory by stating equity rights are followed when people feel 'that they are not *unduly* imposed upon, that they are not *unfairly* ordered about' (2005, p.100 emphasis added). These notions of unfairness and something being undue are created via social expectations - people build expectations on what others should or should not do in particular settings – these expectations can be created via conventions, rules or roles. In this particular setting, the role of the nurse and the patient's expectations of the consultation (due to the regular occurrence of GP surgery visits) would mean that this request would probably not threaten the patient's equity rights as such a request would be expected. Moreover, it is in the patient's own interests (as he wants to get better) and is not undue or unfair in the context.

Via this short extract I have shown how by combining the two theories we can gain further insight into what is happening between the two interlocutors. By using Brown and Levinson I have determined the ways in which a potentially threatening act was mitigated, but illustrated that within this context, the act may not have even been perceived as threatening.

2.3.4.2. *Reciprocity*

Reciprocity has largely been ignored within politeness literature, but is 'a key principle in the contextual dynamics of impoliteness and politeness' (Watts, 2003, p. 19). Spencer-Oatey touches on the idea of reciprocity in her formulation of equity rights as 'the belief that costs and benefits should be "fair" and kept roughly in balance' (Spencer-Oatey, 2005, p. 100) . The idea of reciprocity in the context of a politeness-related theory was first posited by Spencer-Oatey (2008) in terms of a social norm in which behaviour should be matched. Reciprocity will be of importance to this study as I will analyse openings and closings, aspects of talk that are renowned for reciprocal exchanges, for example:

Extract 2: Transcript 4

1.N: Alright (.) take care
2.P: You take care (.) thank you

The closing of this interaction involves the reciprocation of well wishes ('take care'), an example of pos-politeness (Leech, 2014). Here the behaviour of the participants is matched, but it will be noted later in this thesis that reciprocation does not always occur in this setting (see chapter 6).

2.3.4.3. *Activity Types and Frames*

It is argued by a number of researchers that we make sense of the world through past experiences, repeated activities and what we hear. These experiences then cause us to form expectations about the world (Tannen 1979, Terkourafi 2005). These structures of expectation (Tannen 1979) or 'knowledge structures' (Bednarek, 2005) are commonly known as 'frames' and they relate to linguistics as our past experiences can inform us of what language to use in certain situations. For example, through past experience and previous co-occurrence a hint such as 'I'm cold' can be understood and responded to as a polite request to close the window.

One approach to a frame-like notion is that of Levinson (1979), who proposes 'activity types'. Activity types are 'a fuzzy category whose focal members are goal-defined, socially constituted, bounded events with constraints on participants, setting, and so on, but above all on the kinds of allowable contributions' (Levinson, 1979, p. 368). A nursing consultation fits within this definition as it is a joint activity that typically involves a nurse and a patient in a particular setting (which may vary). Both participants have specific goals and their language is usually constrained due to the activity taking place. For example, at the beginning of a consultation with a nurse in a GP office the nurse will commonly summon a patient by calling out their name, due to past experience the patient would know that the correct response would be to follow the nurse into the consultation room.

Levinson states that activity types are goal defined, but this is not restricted to just one goal as the participants pursue many goals at once (Clark, 1996) in a joint activity. The 'domain goal' (ibid.) would be to complete the transaction, whether it be a blood test, a diabetic review or an asthma check. 'Procedural goals' (ibid.) would be to complete the task quickly and painlessly (especially when needles are involved), whilst 'interpersonal goals' would be to build rapport, be polite, maintain patient dignity etc.

The activity types involved in a consultation with a nurse can be grouped together as a larger 'script' (Clark, 1996) i.e. the 'expected course of the joint activities that take place' (p. 109). A consultation with a nurse would typically follow the following script (adapted from Clark's restaurant script):

Script name	Nurse consultation in a GP surgery
Props	Desk, chairs, examination table, medical instruments
Roles	Nurse, patient
Entry Conditions	The patient has an ailment or has been requested to have a procedure done by the surgery
Results	Nurse carries out the procedure
	The nurse gives the patient advice
	The nurse provides a diagnosis (depending on purpose of consultation)

Actions	Patient chooses whether to accept advice/diagnosis
	Nurse summons patient
	Patient enters consultation room
	Nurse confirms/asks reason for patient's visit
	Nurse carries out procedure
	Patient discusses health issues
	Etc.

This script aids in describing the context of my data and within my analysis I will look at a number of activity types and how they contribute to the larger script of nurse-patient consultations.

Anthropologists and sociologists (e.g. Bateson 1972, Frake 1977 and Goffman 1974) define frames differently as they see interactive frames to be an 'interpretation of what is going on' (Holmes, 2006, p. 27) that is shared by participants. Bateson (1972) uses the example of monkeys in that a monkey needs to ascertain whether a push is intended playfully or seriously in order to respond appropriately. This relates to language as speakers can often say hurtful things that they do not really mean, but frame their language as play in order not to cause offence, for example 'You're such a bitch' said by a friend can be framed as play. Interactive frames will be used throughout this thesis, especially when discussing humour use as the interactants continually switch between play frames and serious frames.

2.4. Conclusion

Overall, due to the open nature of an interpersonal pragmatic approach (that combines a number of linguistic approaches), (im)politeness is understood in this thesis as an umbrella term for evaluative meanings that can be understood as either polite, neutral and impolite (Spencer-Oatey 2008). My analysis will take a third-wave approach, namely neo-politeness theory, by combining the analytical categories of Brown and Levinson (1987) with (largely) the addition of Spencer-Oatey's rights as I have shown how these works seamlessly with Brown and Levinson's framework. Finally, I will apply two frame-related notions: one of

activity types, which captures the entire situated activity, and the other of interactive frames, which captures the shifts in understanding of what is going on (e.g. serious to playful).

I will take into account various interpersonal aspects of communication rather than simply focussing on how speakers indicate concern and respect for others (as Brown and Levinson do), by considering the use of frames, the evaluations of the hearer, reciprocity, pos-politeness and above all, the context of the language in use.

CHAPTER 3

3. COMMUNICATION IN HEALTHCARE

3.1. Introduction

It is widely accepted that a positive nurse-patient relationship is vital in order to provide quality nursing care. Consultations with nurses are formed via a content component and a relational component, both of which are important in achieving interactional aims (Britten 2004, Kinmonth et al. 1998). Not only does the nurse have to use task-centred communication, but she/he also has to show compassion, care and empathy; all of which are components of linguistic politeness. Silverman et al. (2005) found that the quality of communication can influence patient outcomes such as their education as well as satisfaction with care and health, thereby highlighting the importance of researching communication within this setting.

In this chapter I will look at a number of features of nurse-patient interactions within the healthcare literature and highlight common issues noted by the research. The structure of the chapter is as follows: In section 3.2. current communication-related issues within the NHS are reported. This is followed by the definition and discussion of a style of communication that is usually evaluated extremely positively: patient-centred communication (section 3.3). Within that section I also discuss task-centred communication, a style that is usually evaluated negatively. Following from this, I discuss respect and power in health communication (section 3.4) and, finally, the chapter moves on to dignity and talk with older patients. Section 3.5 defines patronising talk and covers a range of research surrounding its perception. The chapter is concluded in section 3.6.

3.2. NHS Issues

Recent issues within the national health care system stipulate that communication needs to be improved; issues such as those in Mid-Staffordshire (2010) and

Winterbourne View (2011). The Mid-Staffordshire report stated that there was a culture within the hospital to focus 'on doing the system's business – not that of the patients' and that the hospital staff were using 'standards and methods of measuring compliance which did not focus on the effect of a service on patients'. These two points suggest that communication within this institution needs to be improved and that a more patient-centred approach to medicine should be adopted.

Following from these recent problems within the NHS, various plans of action have been introduced. The NHS commissioning board have introduced the 'Six C's' (2012) to tackle current care issues:

- Care – Patients should consistently be cared for in a way that is suitable and appropriate for their needs and wishes.
- Compassion – Patients should be shown empathy, respect and dignity.
- Competence – Healthcare professionals should have 'expertise, clinical and technical knowledge to deliver effective care and treatments'.
- Communication – In order to build successful relationships with patients and other team members, communication is key.
- Courage – Doing the right thing and speaking up when necessary.
- Commitment – A commitment to improve healthcare and to commit to the populations that the healthcare professionals serve.

A further policy that has been introduced is 'No decision about me, without me' (2012). This proposal aims to 'increase opportunities for patients and their representatives to have more involvement in decisions about their care all along the patient pathway' (p. 4). Further policies specifically related to nursing include the Nursing and Midwifery Council of the UK's code which demands that nurses 'treat people as individuals and uphold their dignity' (2015, p. 4) by showing them kindness, respect and compassion; the Royal College of Nursing's Principles of Practice (2017) furthers these aims. It is clear from the aims of these policies that the NHS is attempting to improve the communication between healthcare professionals and their patients and that showing patients dignity, respect and empathy are key to these improvements; features which are all components of linguistic politeness. This push for improved communication is not just limited to the UK as Kitson et al.

(2013) note, international organisations such as the World Health Organisation (2000) and governments (e.g. US Department of Health and Human Services, 2008; Australian Commission on Safety and Quality in Healthcare, 2010) are promoting a similar patient-centred approach to healthcare.

3.3. Patient-centred Communication

Patient-centred communication is essential in all of the aforementioned policies, but has a variety of definitions throughout the healthcare literature. Kitson et al. define the core aspects of patient-centred communication as 'respecting patient choice and effective communication' (2013, p. 5), but in their review of the surrounding literature they found three main components:

1. Patient participation and involvement
    a. Is the patient given the opportunity to participate in their own care?
    b. Is the care plan based on the individual needs of the patient?
    c. Does the care address the patient's physical and emotional needs?
2. Relationship between the patient and the health professional
    a. Has a relationship been built and is it being supported?
    b. Is there open communication of knowledge?
    c. Does the heath professional have appropriate skills and knowledge?
    d. Is there a cohesive and cooperative team within the setting?
3. The context where the care is delivered
    a. What barriers are there that inhibit patient-centred communication? E.g. Time, lack of equipment etc.

Patient-centred communication is relevant to this study as a patient-centred approach would involve a number of politeness features from the healthcare professional, such as attending to the patient's needs and wants and upholding the patient's dignity. There are a number of reported benefits of patient-centred communication, for example, patients have reported higher satisfaction when given more autonomy in their care (Anderson, 2002) and it is also associated with closer adherence to

treatment plans and improved health (Bikker et al., 2005; Charlton et al., 2008; Mercer et al., 2008).

Evidently, patient-centred communication is a goal for healthcare provider-patient interactions, but is not always what is used. Patients have previously reported negative communicative behaviours such as stereotyping, a lack of friendliness, care and empathy, abuse of power (Cleary, 1999) with a more task-centred approach (McCabe, 2004). The following section will discuss these communication practices in more detail.

3.3.1. *Task-centred*

Task-centred communication can be defined as the healthcare worker primarily focussing on the tasks required to complete a consultation rather than focussing on the individual needs of the patient. There has been a large amount of research that has looked at the use and effects of task-centred communication within a healthcare setting. A recent study by O'Hagan et al. (2014), which presented two simulated videos to nurse educators and clinicians and reported their feedback, showed that the two nurses involved in the videos tended to exclude the patient. The evaluators of the videos said that this approach was 'disregarding the individualised needs of patients' (p. 1350). Drew (1986) studied exclusion and confirmation in hospitalised patients and found that the patients reported feeling sapped of energy when the nurses did not take a patient-centred approach. Another study by Plaas (2002) found that patients felt objectified through a lack of 'humanity' in the healthcare provider's communication. This is further supported by the study of Agledahl et al. (2011) of doctor-patient relationships whereby the doctors were reported as only dealing with medical concerns, showing very little curiosity or care for the individual patient; this resulted in patients being treated as 'medical objects' (p. 651). It is clear from these studies that a task-centred approach can have negative effects on patients.

Some studies quantified the amount of task-centred talk. Kruijver et al. (2001) found that more than half of communication with cancer patients was task-centred while Williams et al. (2005) found that 69% of it was. They also found that very few

conversations lasted longer than five minutes. It seems clear from the literature that nurses adopt a task-centred approach rather than a patient-centred one, in spite of the fact that patients deem a healthcare experience positive when they are treated respectfully, with empathy and dignity (Breeze and Repper 1998, Meruelo 2008, McCabe 2004).

Although patients have reported complaints about feeling objectified, in some studies they comment on the fact that it is not the nurse's fault and that it is due to being extremely busy (McCabe 2004, Caris-Verhallen et al. 1999). Although generally assumed as being the reason for poor communication it has been argued that the length of time spent with a patient does not dramatically affect whether the relationship is positive or not (Altschul 1972). Gilbert (1998) and Hagerty and Patusky (2003) have found that extensive time is not necessary to form a positive relationship and that patient-centred care need not put further time pressure on a nurse.

The most important factors for building a good relationship based on patient responses were genuineness, respect, empathy and warmth (Breeze and Repper 1998, Drew 1986), all of which unsurprisingly appear in the 'Six C's'. There does, however, seem to be a mismatch between what nurses believe to be a good relationship and what patients believe. Jarman (1995) and Jarrett and Payne (2000) reported that nurses do not fully appreciate the importance of a good relationship and this causes them to make assumptions about what a patient needs or wants.

3.4. Respect and Power in Health Communication

One of the clearest themes in the literature is the power-struggle between nurses and their patients. Power is an important variable in the study of politeness: Brown and Levinson (1987) argue that the lower the power of the interactant, the more politeness they generally use. Health encounters provide a somewhat unique setting regarding power and expertise. The nurse's role is that of an expert service-provider, but patients could evaluate themselves as experts in their own health, which could

result in a power struggle. This was noted by Heritage & Sefi (1992) in their study of nurse visits with first-time mothers.

Research into nurse's asserting power over their patients are common, for example Johnson and Webb (1995), found that interactions were rife with conflict as the nurses exerted power over their patients, which eventually resulted in 'acquiescence of patients to the nursing and medical goals of care' (p. 83). Breeze and Repper (1998) found similar results in their study of 'difficult' patients, these patients reported that they felt as though they had 'no control over their treatment and were co-erced or forced into certain behaviours that the staff thought more appropriate' (Shattell, 2004, p. 719). Clearly, the use of power in these interactions appears to reduce patient autonomy and thereby patient-centred care.

However, Parsons (1951, 1975) argues that patients assume the 'sick role' in that they are willing to be passive and dependent in order to receive care. This was also found by Armstrong-Esther and Browne (1986). This passive manner results in patients being reluctant to criticise care and thereby assert what they want, which was also found by Attree (2001) and Pontin and Webb (1996). These results clash with the aims of the 'Six C's' (2012) as the patients appear to be submitting to nurses' decisions rather than being a part of the process. According to Sines (1995), if a more patient-centred approach were adopted it would empower the patient and encourage them to take a more active role in the consultation.

A study by Kettunen et al. (2002) argued that patients constructed their power jointly with nurses and that they used the same power strategies as professionals when asserting power. McQueen (2000) also argues that the power created by nurses and doctors in a patient consultation is diminishing as patient-centred communication and strategies, like 'no decision about me, without me', are being put into practice.

3.5. Dignity in Health Communication

3.5.1. *Older Patients*

A key component of my study is whether there are any differences between nurses' speech with older patients and younger patients. The number of people aged 65 and over is steadily increasing (see section 1.2) and their first point of contact for health related issues is the GP surgery. As previously stated, since 2012 the NHS has been pushing the strategy of 'Compassion in Practice', which promotes individualised, patient-centred care. It is vital for practices to successfully accommodate the health concerns of older patients, whilst also maintaining their dignity and autonomy. Dignity can be achieved through treating a patient with respect and through the perception of value from others – a medical term that can be closely linked to Brown and Levinson's linguistic concept of *positive face* (1987). Similarly, autonomy relates to *negative face* (ibid.) – the freedom and ability to act – as it refers to the patient's control of decision-making. Dignity and autonomy are important for all patients, but are key for older patient care as they can easily become disempowered in the healthcare setting (McWilliam et al., 1994).

In the following section I will review the literature of communication with elderly patients in healthcare settings. Views of older patient identities will be presented as this study looks at the understandings of patients and therefore necessitates an in-depth discussion and comprehension of 'older identities'. Following this, research on 'baby talk' and nurse attitudes towards older patients will be presented and critically reviewed. Finally, I will discuss an approach that is contrary to popular opinion and understandings of 'older speak'.

3.5.1.1. *Older Patient Identity and Stereotypes*

Geriatric patients are often believed to share specific characteristics and priorities (Coupland & Coupland, 1998). Communication with the nurse is seen as more difficult with older patients due to a number of potential barriers, such as 'impaired

hearing and vision, ways of acting and verbal expression differing from that of younger people, cognitive and memory problems' (Kaplan et al., 1995, p. 206). These barriers can make communication more difficult and could prevent a good relationship from forming, so nurses need to tailor their care to the individual needs of each patient and take these potential barriers into consideration.

Older patients are seen as being confronted with a number of problems, such as physical and psychological deterioration, changes to their life patterns and potential loneliness due to loss of family and friends (Caris-Verhallen et al., 1997, p. 915). It is often thought that due to these issues they may long for social interaction and use the nurse's consultation as an excuse for social talk (ibid.), more so than younger patients. However, Greene et al. (1986) discovered, upon analysing 80 doctor-patient interactions in a New York teaching hospital, that older patients did not 'bring non-specific problems of living to their physicians' (ibid., p. 121). Obviously, there are differences to the data Greene et al. procured and my own, the patients were in a hospital, not a general practice, and are Americans who could have differing values to older, British patients. It will be interesting to note if the older patients within my data used more or an equal amount of social talk than younger patients.

Although frequently thought of as a homogenous group with similar problems, it is naïve to think of older patients as such. The needs of patients in their 60s compared to those in their 80s can be vastly different and Mann et al. (2001, p. 65) state that 'even with chronologically matched groups...there are wide variations based on different psychological needs, social supports, medical problems, and health perspectives'. A common issue with geriatric medicine is the negative stereotyping of older patients which provides a reference to which the individual is compared (Rothermund & Brandtstädter, 2003, p. 549). Negative stereotypes can be triggered by physical (grey hair) or interactional cues (vocal quality) (Harwood & Williams, 1998) and can influence the behaviour of caregivers, as found in Kemper's (1994) study in a nursing home, where the patient's age alone led to slower and simplified speech used by the caregivers. However, Giles and Coupland (1991) argue that older people deal with the effects of aging differently – some camouflage the effects (DeVellis et al., 1990), whilst others stereotype themselves (Levy, 1996; Suls et al., 1991). Further to this, research in the 90's started to recognise that not all aging

stereotypes are negative (Hummert et al., 1994; Hummert & Ryan, 1996) and communication with positively stereotyped older people can differ to that with negatively stereotyped ones. Giles and Gasoriek (2011) argue that there are several factors leading to a positive or negative stereotype of aging (for example, age, physical condition, setting etc.) and the compounding of these features can lead to a positive or a negative evaluation of the older person. If the older person is seen as independent, mobile and wise they are more likely to be spoken to with 'normal' speech, whereas a dependent, immobile, depressed older person would be more likely to be the recipient of accommodated speech.

It is expected within the GP setting that a more positive stereotype of older patients will be formed by the nurses as they will typically be independent and mobile (otherwise they would receive home visits). The different values and backgrounds of patients need to be identified and accommodated to by nursing staff. This study will take the differing needs of older patients into consideration and patients will be asked about their personal preferences of approaches to care. I will note whether the interaction that took place between them and the nurse reflected individual care and whether they perceived patronising talk to occur.

3.5.1.2. *Secondary-Baby Talk and Patronising Talk*

'Specific ageist assumptions about older people are legion: they can't hear, they can't remember, they can't think for themselves, they are depressing, they are non-productive, they are infantile' (Greene et al., 1986, p.113). These negative stereotypes lead to the use of 'secondary baby-talk' by health professionals, which is said to be 'an attempt to reconcile the caring approach that nurses are expected to have, while actually operating in a controlling manner and adopting the role of parent' (Kenwright, 1998, p. 25).

The ageist stereotypes held by healthcare professionals are said to be 'an occupational hazard' (Greene et al., 1986, p. 113) because they are constantly in contact with the frail, the ill and the confused. A number of studies have identified negative nurse attitudes towards older patients (Armstrong-Esther et al., 1994;

Lookinland & Anson, 1995; Treharne, 1990), which have been linked to an authoritative attitude and the exertion of power (Hewison, 1995; Park & Song, 2005). Makoni and Grainger (2002) claim that this controlling dimension of nurse-elderly patient interaction takes precedence over any other mode of discourse. Even when the nurses use playful or endearing language, it merely serves 'to secure the controlling position of the nurses, while at the same time satisfying the professional requirement of apparent benevolence and concern' (ibid. p. 821). These studies were all carried out in care homes, however, and as my data is from a GP surgery the older patients are expected to be more autonomous and independent, making the nurses less likely to negatively stereotype and act authoritatively with the patients. This will need to be tested in the data.

A plethora of studies have looked at the different features of this authoritative language use - 'secondary baby-talk', defining it as a voice register that includes high pitch, slow tempo and exaggerated intonation (Brown, 1977; Caporael, 1981; Ryan et al., 1994). A number of discursive features have also been identified as elements of secondary baby-talk/patronising talk. Marsden and Holmes (2014) provide an extensive list in their work on communication with older patients in New Zealand residential care settings, a copy of which can be found below:

- a high incidence of repetition;
- simplified structures in phonology, morphology, lexis and syntax;
- imperatives (e.g. 'get up') (Grainger, 1993; Herman & Williams, 2009; Ryan et al., 1995);
- terms of endearment and diminutives (e.g. sweetie) (Backhaus, 2009; Grainger, 1993; Herman & Williams, 2009; Makoni & Grainger, 2002; Sachweh, 1998);
- collective plural pronouns used to address individuals (e.g. 'would we like a cup of tea?') (Herman & Williams, 2009; Lanceley, 1985; Makoni & Grainger, 2002; Sachweh, 1998);
- high frequency of tag questions (e.g. 'you like your biscuits, don't you?') (Herman & Williams, 2009; Ryan et al., 1995);
- high frequency of modal verbs (Lanceley, 1985)
- use of first names (Backhaus, 2009; Grainger, 1993; Ryan et al., 1995);

- frequent praise (e.g. 'good girl') (Backhaus, 2009; Grainger, 1993; Makoni & Grainger, 2002; Sachweh, 1998);

- third person reference in the presence of the person being referred to (e.g. 'he's tired today') (Lanceley, 1985; Ryan et al., 1995; Makoni and Grainger, 2002, p. 820);

- limited topic selection due to a focus on task-oriented topics (Grainger et al., 1990; Grainger, 1993; Ryan et al., 1995)

• frequent interruptions of the residents by the caregivers (Ryan et al., 1995);

• relative absence of (especially social) talk overall (Grainger, 1993; Grainger et al., 1990; Ryan et al., 1995).

<div style="text-align: right">(Marsden & Holmes, 2014, pp. 18-19)</div>

These discursive features will be analysed throughout my data to see whether there is a difference in the communication with older patients and younger patients. I will look at whether there is a higher frequency of these elements with older patients or, on the other hand, a lack of them in speech with younger people. In contrast to earlier studies (e.g. Ryan et. al 1995, Caporael 1981) I will look at the social context of the interaction and bear in mind the relationship between the interactants, viewing the talk as co-constructed, similar to Marsden and Holmes' (2014) research.

Secondary baby-talk is generally perceived as negative behaviour and is often seen as patronising. A number of researchers have looked into older people's perception of this style of speech. For example, Caporael (1981) and Caporael et al. (1983) studied the evaluations of 60 nursing-home residents to audio-recorded interactions containing baby-talk and found that the most autonomous residents disliked the style of speech and upon erasing any contextual data from the recordings, 75% of respondents in the 1981 study could not distinguish the language used to older residents than that used by teachers to nursery children. Similarly, Ryan et al. (1991) carried out a study where 186 older participants rated the language of two scripts, one containing baby-talk and the other not; the participants found the baby-talk transcript to be less respectful and nurturing. Finally, Edwards and Noller (1993) and Herman and Williams (2009) have argued that there is evidence to suggest baby-talk can be inimical to the patient's psychological and physical health.

There are a number of issues that could be used to argue against the findings of these

studies. The transcripts and recordings were taken out of context and the participants were not given contextual information about the speakers. One could not know if the speakers had a very close relationship and the usage of these terms actually built rapport rather than threatened it. Caporeal's studies would be more reliable as they use recordings, and pitch and tone could display the relationship between the actors in some form, but Ryan et al.'s data could have resulted in much more ambiguity in the meaning of the utterances.

3.5.1.3. *Caring or Courteous?*

A more cynical view of politeness strategies (especially surrounding requests), such as terms of endearment and gentle tone, is that caregivers may use these face-saving strategies to 'allow the routine to continue without undermining the nurturing role of the nurse. It is superficially relation-oriented, but ultimately orients to the supreme institutional goal of getting the work routine completed' (Grainger, 1993, p. 256). Makoni and Grainger (2002), in their study of care homes in South Africa and the United Kingdom, suggest caregivers may feign interest in their patients in order to complete physical care tasks. They argue that this may be done to 'balance the twin requirements of efficiency…and showing concern' (2002, p. 822).

According to Agledahl et al. (2011); Grainger (2004a) as well as Grainger (2004b), superficial care does not just occur in and around given tasks (or directives), but can be used throughout to ease the consultation process. In their study of doctors' communication in a hospital in Norway, Agledahl et al. (2011, p. 651) found that doctors often displayed 'a friendly attitude, kept a good tone and emphasised the social relationship with the patient', but their main focus was on the medical problems and not care. Other studies have highlighted that patients are aware of this issue and state that nurses working without a sincere attitude can inhibit the nurse-patient relationship (Armstrong-Esther et al., 1994; Nolan et al., 1995; Park & Song, 2005). When analysing my data, specifically with directives/requests, I will attempt to ascertain whether face-saving strategies are used to oil the wheels of the consultation process rather than to build rapport and show care. The patients' evaluations will also be taken into consideration via use of post-consultation

interviews.

3.5.1.4. *Can Baby-talk Actually Nurture?*

An alternative perspective is that baby-talk achieves its supposed purpose of nurturing and its meaning is subject to the understandings of the recipients. Focusing on the prosodic features of baby-talk, Cohen and Faulkner (1986) compared the recall of 30 older people and 30 younger people of newspaper clippings. They found that the older participants had better recall and comprehension when stress was placed in optimal locations, claiming 'stress is effectively pre-processing the message for the listener and that acoustic enhancement could therefore be a great assistance in compensating for a reduction in processing capacity' (1986, p. 92). Some older patients have reported positive reactions to baby-talk in that it makes them feel better about themselves (Edwards & Noller, 1993) and signals caring and affection from the healthcare staff (Ryan et al., 1986).

A more recent and contextually sensitive study by Marsden and Holmes (2014) questions the view that 'baby-talk' is negatively perceived and posits the idea that this type of talk promotes solidarity when analysed in context. They see the relationship of caregivers and the elderly as multi-dimensional rather than the typical view of the professional simply imposing their power on the passive older patient.

Marsden and Holmes recorded interactions in two New Zealand residential eldercare facilities. They analyse terms of endearment, directives, the use of small talk and humour, whilst taking into account the contextual setting. Contrary to previous literature the findings suggested that terms of endearment were used reciprocally, social talk was preferred over transactional talk by the caregivers and humour was cooperative. All these features suggest that building rapport and a strong relationship was important to the participants. It was also noted that directives were always mitigated through the use of less direct structures (e.g. conventionally indirect, 'let's' requests) and devices, such as terms of endearment, discourse markers and the patient's name. These devices were not regarded as 'baby-talk' as decisions were collaborated and negotiated with the patient – as Marsden and Holmes stated, 'the

importance of the relational dimension was evident in the linguistic choices that caregivers made' (2014, p. 31).

3.6. Conclusion

Overall, this chapter has outlined a number of issues within healthcare communication. The research has reported that task-centred communication typically occurs within this context, but a push for more patient-centred communication has come from governing bodies. Further to task-centred talk, research has noted the use of patronising/baby-talk with older patients, but research is divided into whether this talk is evaluated positively or negatively. Throughout my analysis I will look at the talk used with both younger and older adults, taking the patients' perspectives into consideration to determine whether this language is seen as positive or negative, if it occurs at all.

CHAPTER 4

4. FEATURES WITHIN A MEDICAL INTERACTION

4.1. Introduction

This chapter will outline research within both the healthcare and linguistic fields that is directly relevant to my analysis chapters. Section 4.2. refers to the typical stages of doctor-patient and nurse-patient interactions and how this will be relevant to my study. Section 4.3. reviews the literature on openings and closings in healthcare interactions, taking a more detailed look at their typical structure, whilst also gaining an understanding of patient preferences in these phases of the interaction. Section 4.4. initially reviews the linguistic analysis of requests and is followed by a summary of the research that studies requests in healthcare settings. The subsequent section refers to my last analysis chapter by reviewing the literature on humour. The section begins with a look at the healthcare literature and is followed by a linguistic view of humour. Finally, the chapter is concluded in section 4.7.

4.2. The Typical Structure of Healthcare Consultations

Heritage and Maynard (2006) note that most interactions include some form of structural features, for example, openings and closings (Schegloff & Sacks, 1973), but medical consultations, due to their institutional, task-focused nature, have a more 'specific internal shape' (Heritage & Maynard, 2006, p. 15) . The study of phases within the medical interaction was started by Byrne and Long (1976) in their study of nearly 2500 medical encounters. They identified six phases of the medical encounter:

- The doctor establishes a relationship with the patient
- The doctor discovers the reason for the visit
- The doctor conducts a verbal or physical examination
- The doctor establishes further treatment or investigation
- The consultation is terminated

Similar structures were found by Heritage and Maynard (2006) and ten Have (1989), who argue the following typical structure of doctor consultations: opening, complaint, examination, diagnosis, treatment or advice and closing. All three of these researchers suggest that these typical structures are 'ideal' and that many deviations may occur in actual consultations.

The analysis of the structure of nurse-patient interactions is less studied, but nursing textbooks provide a basic three-phase structure of introduction, active data collection and conclusion (Northouse & Northouse, 1992; Weber & Kelley, 2013). There are a small number of empirical studies that have looked at the phases of nurse-patient interactions; for example, Johnson (1993) studied 24 interactions and developed a common structure of establishing the agenda, eliciting information from the patient, doing a physical examination and planning future care. MacDonald (2007) added relational practice to Johnson's list, covering social talk and providing emotional support. Finally, a corpus study by Staples (2015) built a more in-depth structure of nurse-patient interactions based on 102 video recordings.

Table 1: Staples' (2015) phases of nurse-patient interactions

Phase	Elements contained with phase
Opening	Greetings
	Small talk
	Orientation of patient to environment and interaction
	Acknowledgments of the patient's current condition
Complaint	Nurse's elicitation of primary complaint
	Patient's primary complaint
Exam	History
	Past health and medical history, family history, procedures and treatment
	Physical exam
	Indications of the nurse's upcoming actions
	Online reports on patient's condition or

	reports from chart
Counsel	Diagnosis/possible diagnosis
	Health-related information
	Recommendations for treatment
	Counselling
	Reference to plan of care (e.g. doctor's follow up)
	Discussion of goals
Closing	Summary of arrangements
	Asking for further questions or concerns
	Reminder of how to contact nurse
	Expressions of future contact
	Terminal exchange

(Staples, 2015, p. 33)

As noted by Heritage and Maynard (2006, p. 15) generating phases of interactions is not aimed to build a taxonomy, but to provide 'access to understandings about the nature of the medical visit which are drawn upon by physicians and patients in their joint management of its progress'. By referring to these phases of interaction I will be able to compare my data to 'ideal' consultations and uncover ways in which participants manage talk around these phases.

4.3. Politeness and Openings and Closings

4.3.1. *Openings*

The start of conversations typically involve a greeting with a term of address and a 'how are you' sequence – these beginnings of interaction are known as *openings* in conversation analysis. The openings of any interaction 'open communicative acts and set the tone for the interchanges that follow' (Wood & Kroger, 1991, p. 145), but within a medical setting they also give the healthcare worker an opportunity to create positive first impressions and build rapport (Byrne & Long, 1976). Openings can be seen to build trust between interactants and lead to setting 'the scene for efficient and

accurate information exchange as the interview unfolds' (Silverman et al., 2005, p. 41).

The typical structure of geriatric outpatient clinics was noted by Coupland et al. (1994) and included:

- Summons/approach – consultations typically opened with a summons from the doctor and the patient entering the room
- Greetings – The doctor typically greets the patient first in a greetings exchange
- Dispositional talk – Includes the doctor directing the patient to sit down
- Familiarity sequence – serves to establish pre-knowledge concerning the doctor's and patient's identity or their relationship
- Holding sequence – doctor reads patient's notes
- How are you? – type exchange

This opening 'norm' is similar to the findings of Heath (1981, p. 73-76), who found the opening phases of GP-patient interactions to include a greetings sequence, an identity check, the doctor reading health records and a first topic initiator, which could be phrased as a 'how are you' question or could refer to previous consultations, such as 'How is your foot doing?'. A more recent study by Staples (2015) looked at the structure of nurse-patient interactions within two American hospitals. The opening phases according to Staples included greetings, small talk, orientation of the patient to environment and interaction, and acknowledgements of the patient's current condition (ibid. p. 33). Staples did not include first topic initiators within the opening of the consultation, but separated these into a phase called 'complaint'; however I will analyse topic initiators within the opening phase of the consultation. Within my study I will note typical features of the opening and note differences between my data and these previous studies.

I will now discuss a number of the typical features of openings in more detail, referring to relevant literature and building hypotheses about my own data.

4.3.1.1. *Greetings*

Greetings are commonly understood to consist of an adjacency pair (Schegloff & Sacks, 1973), an utterance pair produced by different speakers that is composed of conventional parts, for example, a greeting would be responded to with another greeting (hello-hi). The research of Robinson (1998) and Coupland et al. (1994) found that greetings were ubiquitous in doctor-patient openings. A previous study of mine (Lunan 2010) found that in nurse-patient interactions nurses claimed that they would introduce themselves and warmly greet the patient (e.g. 'good afternoon'). However, this study was based upon nurse questionnaires and perceptions of what they typically say and the actual utterances they use can vary greatly (Holmes, 1991).

In contrast to these findings, Mercer et al. (2008) interviewed 81 patients in a US hospital and discovered only 54% felt that hospital staff greeted them appropriately. I will analyse the use of greetings throughout my data to see whether they occur as frequently as the aforementioned study suggested.

4.3.1.1. *Introductions and Forms of Address*

The ways in which interactants introduce themselves or address others can have a large impact on the interaction that follows, especially in establishing the distance and power of the interlocutors (Ervin-Tripp, 1969). Knowing the nurse's name has been argued to 'help to put patients at ease, make patients feel more comfortable, improve patient satisfaction and reduce complaints' (Lee, 2011, p. 204).

Despite the aforementioned positive responses to introductions, they are often missing from hospital discourse. Maguire et al. (1986) found that in their study of 36 doctors in a Manchester hospital, only 40% introduced themselves and discussed the task at hand. This is furthered by the more recent issue of a lack of introductions in the #hellomynameis online campaign ran by Kate Granger, a doctor who had terminal cancer. During her visits to the hospital she became increasingly aware of the lack of doctor introductions and felt disempowered and distrusting of the doctors

(Granger, 2015). The NHS has responded to this problem by making it a campaign within hospitals – it would be of value to note whether this campaign has spread to GP practices as well by looking at opening interactions in my dataset.

Coupland et al. (1994) found more positive patterns in their study of geriatric patient and doctor consultations. It was discovered that doctors would establish rapport through introducing themselves, using a patient's name in the greeting sequence and welcoming them. However, one must take this finding with a pinch of salt as Coupland et al.'s study took place in a highly progressive clinic that had a focus on holistic medicine and staff acknowledged that patients may be treated differently at other institutions.

The general view is that British patients prefer to be told the health worker's name in a more formal manner (for example, 'Dr. Wilson') (Henneman & Cardin, 2014; McKinstry, 1990; O'Connor et al., 2011), because it is seen as more professional. However, as noted by Henneman and Cardin (2014, p. 64), 'the current standard for professional nursing introductions for nurses providing direct patient care is at best unclear at worse non-existent', which is similar to the findings in the literature discussed above. The literature suggests that there will be a lack of introductions within the healthcare setting and it will be noted whether this is consistent with my data.

Although British patients seem to prefer a formal introduction of the health worker, it has been suggested that they would rather the nurses and doctors use the patients' first names (McKinstry, 1990; O'Connor et al., 2011). A first name approach seems to have been adopted by healthcare workers and the NHS to make treatments more humanised and is generally viewed positively (Hook, 1984, p. 266). Despite the attempt at a warmer approach, some patients may see the usage of their first name to be patronising (Conant, 1983; Dudley & Baker, 1988) and older patients, who are accustomed to being referred to formally, may see the usage of their first name as a rule violation (Dowd, 1981). I will note the differences in terms of address used with the patients to discover whether their age contributes to how the nurses refer to them and also, if they like to be referred to in that way.

4.3.1.2. *Small Talk*

Taking a more linguistic approach, openings are seen as a form of 'phatic communion' (Malinowski, 1923), which is described as 'free, aimless social intercourse [that] is the first act to establish links of fellowship' (Malinowski, 1936, pp. 313-314). Further to this, Thomas et al. (1982, p. 148) see phatic communion as 'speech that initiates conversation, but [is]... ritualised, such as "hello", "how are you" etc.'. Phatic talk (or small talk) is generally seen negatively, in that it is 'dull' (Leech, 1974, p. 62), 'empty' (Turner, 1973, p. 212), insignificant and aimless. I would tend to disagree with this pessimistic view and argue that some forms of phatic talk are worthwhile, especially to people in vulnerable situations. For example, Holmes and Major (2003) found that phatic talk was used to distract from painful procedures.

Laver (1975, 1981) focused on the more positive aspects of phatic communion, in that it has three main functions during an opening:

• to break silences (which are often seen as awkward);
• to help participants find a working consensus;
• to start the interaction in an easy manner; I would expect these to be the typical purposes of phatic communion and small talk in a nurse-patient interaction.

4.3.1.3. *'How are you?' Sequences*

'How are you' questions are commonly viewed as a form of phatic communion in that the respondent is typically expected to answer in a neutral or positive manner (e.g. 'not bad' or 'yeah good thanks'). Sacks (1975) describes this phenomenon as the answerer determining whether the asker can receive a true response at this time, be it positive, neutral or negative, and deeming a neutral response to be the most appropriate for the situation.

The same question is argued to be much more complex in a healthcare setting as it could be a diagnostic elicitation due to the context. According to Heath (1981), 'how are you?' is used as a first topic initiator to open a healthcare worker initiated

consultation, whereas Gafaranga and Britten (2005) and Robinson (2006) see 'how are you' as an elicitor for a consultation that is not the first in a series. Either way, it is seen as context dependent and an example of 'inferential frameworks and procedures that are typical to specific institutional contexts' (Heritage, 1997, p. 164).

If this were always the case, the analysis of 'how are you' would be straightforward. However, as Coupland et al. (1992) and Gafaranga and Britten (2003) have discovered:

> in medical consultations, "How are you?" can have either of two meanings. It can be part of an everyday greeting sequence and it can be a first concern elicitor. Therefore, a patient may sometimes take it to have the first meaning while the doctor meant it to have the second, i.e. the doctor might be operating in 'the voice of medicine' while the patient is working in 'the voice of the life world'. This is particularly likely if a close relationship already exists between a doctor and a patient.
>
> (Gafaranga & Britten, 2003, p. 244)

I would expect to find both phatic and medical answers to this question in my data and will make note of whether social distance is a factor in the patients seeing the question as phatic or not.

4.3.2. *Closings*

The closings of interactions in a healthcare environment can be extremely important as they can influence the patient's satisfaction, improve follow-up care and even affect the outcome of the patient's ailment (Di Mateo & Di Nicola, 1985; Svarstad, 1976; White et al., 1997). Despite this, there has been little recent research into how consultations are closed, especially in regard to nurse-patient communication.

In order to initiate a closing sequence participants need to establish an appropriate environment, for example, a speaker cannot just utter 'goodbye' in the middle of a conversation (Schegloff & Sacks, 1973). Instead, 'physicians and patients must collaboratively work to suspend the transition relevance of possible

turn completion such that stopping talking or leaving is understood as ending the encounter' (Robinson, 2001, p. 641). White et al. (1997), in their study of 22 recorded doctor-patient interactions, discovered that doctors initiated 91% of closings, suggesting a larger amount of power as the doctor-controlled topic initiation and when the consultation ended. Healthcare workers may activate a closing via orienting towards topics that can be classed as pre-closings (Schegloff & Sacks, 1973), such as treatment discussion (Heath, 1986). The most common form of 'designedly-last' (Schegloff & Sacks, 1973) topics in medical interactions (these communicate to the patient that upon the topic's completion a closing-relevant environment will have been made) is making future arrangements (Heath, 1986; West, 2006; White et al., 1997). This is unsurprising as primary care involves providing patients with management suggestions for a particular complaint (Heath, 1986). White et al. (1997) asked a listening group to define the closing sequence of 22 recorded doctor-patient interactions. The patients concluded that:

> closure is the phase of the medical encounter after the education and information exchange in which the doctor and patient finalise plans and say goodbye. Notably, closure contains a shift in the medical interview from a present to a future orientation.
>
> (1997, p. 158)

Their research also led to a list of closing topics that are introduced by doctors, including emotion, clarification, education and parting comments. It will be of interest to see whether the nurses' communication is similar to that of doctors within my dataset.

A more recent study of a corpus of 102 nurse-patient interactions in American hospitals revealed that typical nurse-patient closings involved the following phases:

- Summary of arrangements
- Asking for further questions
- Reminder of how to contact nurse
- Expressions of future contact
- Terminal exchange   (Staples, 2015, p. 33)

According to Staples' data, the closings of nurse interactions are similar to those with doctors, but Staples' data could differ from my own due to differences in setting and cultural differences.

When analysing the responses of patients to pre-closings, both the studies of White et al. (1997) and West (2006) found that patients did not typically introduce new topics when asked about further issues and generally displayed agreement with the doctor.

4.4. **Politeness and Requests**

4.4.1. *Linguistic Approaches to Requests*

Requests are speech acts 'designed to get someone to do something' (Goodwin, 2006, p. 517). I have previously addressed the features of requests (section 2.2.1), but will outline some key features to remind the reader. Searle (1976) classifies requests as directives in that their illocutionary point is to get the hearer to do something for the speaker (1976, p.11). Directives form an umbrella category including, but not limited to: order, request, demand, advise, beg and offer. A request is associated with the following 'rules':

Propositional content: Future act (A) of Hearer (H)

Preparatory conditions: 1. H is able to do A. Speaker (S) believes H is able to do A.

2. It is not obvious to both S and H that H will do A in the normal course of events of his own accord.

Sincerity condition: S wants H to do A.

Essential condition: Counts as an attempt to get H to do A.

(Searle, 1969, p. 66)

(For a more detailed discussion of the potential features of a request see Culpeper and Archer (2008)). Directives play a large role in nurse-patient communication, whether the nurse utters a request that requires immediate action, such as 'pop on the scales' or a future action 'don't drink anything the day before'. Not only this, but they are central to Brown and Levinson's (1987) politeness theory as requests can be face-threatening to the hearer due to reducing their autonomy. In order to reduce potential face threat and increase the chances of compliance with the act, 'it is necessary to formulate [requests] in a socially and culturally appropriate way' (Ogiermann, 2009, p. 190). This is argued to be achieved 'by using a more…indirect kind of illocution' (Leech, 1983, p. 108) to increase politeness via increasing optionality for the hearer.

A number of requestive strategy taxonomies have been produced throughout the years. One of the most frequently applied is that of Blum-Kulka et al. (1989) who designed their framework based on an extensive corpus of written material using discourse completion tests. Requests according to Blum-Kulka et al. (1989) can include alerters, supportive moves and a head act. For example, in transcript 13 the nurse is trying to arrange another appointment with the patient:

N: Jane (.) let me ring you because I know I am off with the kids one of these m-
(name has been changed)

The alerter in this example is the patient's name as it serves as an attention-getter, the request proper of 'let me ring you' is the head act as it works as a request independently and finally, the grounder (Edmondson, 1981) of 'because I know…' works as a supportive move as it provides the reason for the request. Supportive moves can also precede the head act, such as checks on availability or attempts to get pre-commitment.

Head acts vary by strategy type and perspective. Perspective refers to whether the act is speaker oriented, as in 'Can I just weigh you?' (Transcript 91) as opposed to hearer oriented 'Do you want to nip on these scales' (Transcript 10). They can also be inclusive 'Can we do your weight while you're here' (not in data) or impersonal

'Your weight needs to be taken' (not in data). Strategy types are separated into nine mutually exclusive categories:

1. Mood derivable
2. Performatives
3. Hedged performatives   Direct strategies
4. Obligation statements
5. Want statements
6. Suggestory formulae   Conventionally indirect strategies
7. Query preparatory
8. Strong hints   Non-conventionally indirect strategies
9. Mild hints
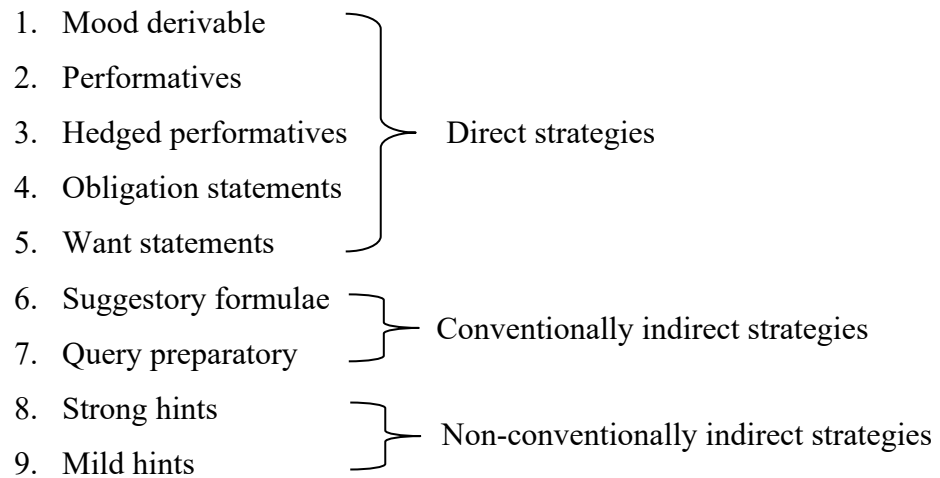
Figure 3: Blum-Kulka et al.'s request typology

(Blum-Kulka et al., 1989b, p. 18)

The requests are separated into three broad categories of direct strategies (1-5), conventionally indirect strategies (6 & 7) and non-conventionally indirect strategies (8-9). The strategies can be softened or heightened by the use of mitigation, which can occur internally (within the head act) or externally (supportive moves).

Blum-Kulka et al.'s strategy types were disregarded due to a number of issues that arose when attempting to apply them to my data. Firstly, there are clear methodological differences between Blum-Kulka et al.'s dataset and my own. The framework was built upon the requests participants think they would say in specific situations, whereas my data uses naturally-occurring iterations of requests in an institutional context. The issues with Blum-Kulka et al.'s methodology are highlighted by Holmes (1991, p. 120) when she states 'it cannot claim to represent what people actually say in interactions but only what they report they would say in a kind of written role play'. This sentiment was supported by the research of Culpeper and Archer (2008); Wolfson et al. (1989) Wolfson et al. (1989) and Beebe and Clark Cummings (1985). Beebe and Cummings (2006, p. 80), in their comparison of naturally-occurring refusals and discourse completion test refusals, concluded that although discourse completion tests allow researchers to gather an

idea of the stereotypical shape of a speech act, they do not account for requests that are built over a number of turns or include repetition; tone cannot be determined and the range of formulas used can be limited.

The categories of requests listed by Blum-Kulka et al. are, at times, too broad and the distinction between strategies was often found to be blurry. For example, Culpeper and Archer (2008) found that want statements fit Searle's definition of an indirect request, being an assertion performing as a request, whereas Blum-Kulka et al. put want statements in their direct strategy category. Culpeper and Archer (2008) found further issue with the definition of requests, specifically obligation statements as according to Blum-Kulka et al. these requests place obligation on the target, but Culpeper and Archer found examples where obligation was placed on the speaker or both participants, for example, 'I must speak to you' versus 'You need to talk to me'. The change in viewpoint makes the request less direct and so placing these requests in the same category could affect understandings of direct request usage. Aijmer's (1996) framework deals with this by separating these two requests (strategies 5 and 6 shown below).

Beebe and Cummings (2006) highlighted that the range of formulas used in discourse completion tests can be limited, which may have contributed to my next issue with Blum-Kulka et al.'s taxonomy. An issue that is extremely pertinent to my data was the lack of categorization for 'let requests' (for example, 'let me open that for you') in Blum-Kulka et al.'s taxonomy. These requests are oddly absent from the Blum Kulka et al.'s data (CCSARP), but occur frequently throughout my data, in the London-Lund Corpus that was used by Aijmer (1996) and in the historical data used by Culpeper and Archer (2008). Aijmer compares 'let me' with 'can I' and argues that the illocutionary force of a suggestion is created by both forms and therefore categorises let-requests as permission questions (strategy 11).

Due to these issues I chose to use the taxonomy by Aijmer (1996) rather than Blum-Kulka et al. in order to study specific pragmalinguistic realisations of requests in more detail. Aijmer's taxonomy was built using the London-Lund Corpus, an extensive corpus that uses non-elicited data, a methodology that is similar to my own, Aijmer's analysis also led to a larger variety of request features and functions.

Aijmer moves away from the traditional focus of direct and indirect requests and instead emphasises the 'forms and patterns encoding requests and their situational and pragmatic constraints' (1996, p. 124). Her taxonomy works better with my data due to distinguishing detailed categories that are easily identifiable and allow for different functions of requests to be unearthed. Aijmer's taxonomy of requests is as follows:

1. Ability – Asking about hearer's ability to do something (Can you…)
2. Consultation – Asking about the possibility of the desired act (Is it possible..)
3. Willingness – Asking whether the hearer is willing to do the act (Will you..)
4. Want – Expressing a desire for the act to be done (I would like you to…)
5. Need – Expressing a need for the act to be done (I need you to…)
6. Obligation – Stating an obligation for the act to be done (You must..)
7. Appropriacy – Stating that it would be appropriate for the act to be done (You should..)
8. WH-question – Asking an idiomatic wh-question (What about…)
9. Hypothesis – Referring to a hypothetical action (If you would…)
10. Appreciation – Expressing appreciation for the realization of an act (I would be grateful if you would..)
11. Permission Question – Asking permission to do something (May I, let me…)
12. Possibility – Asserting that it is possible for the hearer to do something (You can…)
13. Preference – Stating that an act is preferable (You had better…)
14. Performative – Referring explicitly to the act of requesting (I was going to suggest…)
15. State – Referring to a state that needs to be changed (There is a crack in the windscreen)
16. Naming – Naming the object requested (The pen (please))
17. Existence – Checking availability of the desired object (Is Mr Jones there?)
18. Other (e.g. giving a justification for a request)

(Aijmer, 1996, pp. 132-133)

Aijmer highlights different functions of requests according to whether they benefit the speaker or the hearer. She separates requestive strategies, which benefit the speaker (1, 2, 3, 4, 5, 6, 11, 12, 15, 16 and 17), from advisories, which benefit the hearer (7, 8, 9, 10 and 13). These distinctions will be useful in my analysis as I assume many requests used by the nurses will largely benefit the hearer e.g. 'You should take these tablets twice a day'.

4.4.1.1. *Mitigation*

A way of softening directives is via the use of mitigation. Fraser (1980, p. 342) defines mitigation as reducing the strength of a speech act when its effects are unwelcome to the hearer. Brown and Levinson (1987) discuss a number of strategies to lessen a face threat in their framework according to positive and negative politeness, as discussed in section 2.3.1.1. However, Faerch and Kasper (1989) separate these strategies further by categorising them as internal or external modifiers. External modifiers occur before or after the request proper and can be of considerable length, whereas internal modifiers are typically short and tone down the request within the request itself. See, for example, the following excerpt from transcript 90:

Extract 3: Transcript 90

N: Don't try and get down just please (.) you're dizzy

Here, the nurse first uses the internal modifiers 'just' (negative politeness – minimiser) and 'please' (positive politeness – politeness marker) and then uses a clipped grounder of 'you're dizzy' (negative politeness – give reasons) to justify the request to the patient. As Aijmer argues, 'there is probably no strict boundary between internal and external modifiers' (1996, p. 170), but differentiating between the two, at least in my quantitative analysis, should allow me to find patterns in mitigation usage by the nurses.

4.4.2. *Healthcare Literature and Requests*

Institutional settings present 'an ideal site to examine the use of face-redressive politeness strategies' (Harris, 2003, p. 31), due to differences in relative power, and are therefore likely to reveal institutional norms. Nurses are generally understood to possess power whilst patients lack it (Draper 1996). This is thought to be due to the role of the nurse as an 'expert' (Grainger, 1993) and their dominance in turn and topic management (Drew and Heritage 1992, Hewison 1995, Coupland et al., 1994). By applying a neo-politeness approach (Holmes & Marra, 2014), I will move beyond the limited contextual factors listed by Brown and Levinson (1987) of power and social distance, and also consider occupational and institutional roles that are no doubt important to establishing norms within this setting (Coupland et al., 1988, p. 200).

Research into workplace discourse, as noted by Marsden and Holmes (2014, p. 22) has demonstrated that

> the same person in the same social context may use a wide range of directives depending on factors such as the position of the directive within the discourse, its precise function at the time, and dynamic features such as different positionings or roles of participants, and more or less relevant aspects of identity construction at different points in the interaction (Holmes et al., 1999; Holmes, 2000; Holmes and Stubbe, 2003; Vine 2004).

Grainger (1993) in her study of geriatric hospitals found that the most prevalent kind of discourse between carers and their patients was 'routine management discourse', which typically entailed directives and informatives. She argued that this style of discourse sustained 'a controlling and managerial identity for the nurses' (p. 251). Clearly, directives are prevalent in nurse-patient interactions and these directives can often 'impinge upon clients' autonomy or privacy' (Spiers, 1998, p.29). It is how the healthcare professionals attempt to mitigate these potential face threats that could help to build rapport and make the consultation as comfortable as possible for the patients.

Research into the usage of directives has resulted in some conflicting findings. While Marsden and Holmes (2014) found no examples of explicit directives, involving just

a bare imperative form, in their study of older patient communication in New Zealand, Mulholland (1994) in her study of 350 general practice consultations (between doctors and patients) found a large amount of unmitigated multiple directives targeted at the patient.

The mitigation that occurs in and around requests is also disputed, as Backhaus (2009), Harrison and Barlow (2009) and Coupland et al. (1988) all discovered that positive politeness is widely used by nurses and doctors to lessen the face threats that they pose. Coupland et al. found many threats being mitigated through praise, giving reasons and in-group identity markers whereas Backhaus argued that praise as well as exclusive and inclusive joking were typical strategies. These studies would suggest that positive politeness is the most common form of politeness being used in healthcare worker and patient interactions.

However, a study by Aronsson and Sätterlund-Larsson (1987) found the use of indirect requests, a negative politeness strategy, to be extremely prominent in doctor-patient consultations. They also found hedges and minimizations of the imposition scattered throughout the doctors requests. Positive politeness strategies were also present in their study, such as in-group identity markers, but negative strategies were used more frequently.

These differences in findings could be a result of differences in healthcare settings, social and cultural expectations or, as Mulholland (1994) argues, whether the request requires immediate compliance or is seeking longer-term behaviour changes. Evidently, there are a number of factors that can affect the articulation of directives and I aim to uncover potential trends in their usage by nurses within the GP setting, whilst also arguing why particular forms may be used and what their potential effects on the hearer are.

4.5. Politeness and Humour

Healthcare literature is filled with stipulations of how humour is to be used in a consultation:

- Be sensitive to the timing, placement and amount of humour (Åstedt-Kurki et al., 2001; Tanay et al., 2014)

- Ensure patients are amenable to humour (Herth, 1990; Schultes, 1997)

- Only use humour that is appropriate to the individual patient's interests (Sumners, 1990; Wender, 1996)

- Avoid instances of sarcasm and aggression whilst attempting humour (Buxman, 2000)

- Do not use humour to exert power (Meyer, 2000)

- Do not view humour as a panacea (Scholl & Ragan, 2003)

- Avoid sensitive areas such as ethnicity, politics, sex and religion (McCreaddie, 2008, 2010)

- Avoid use of humour during times of crises or psychological distress (Dean & Gregory, 2005; McCreaddie & Wiggins, 2008)

(List updated from Scholl (2007))

With so many contexts and topics to be avoided when using humour it is understandable that it is commonly an 'untapped resource' (Åstedt-Kurki et al., 2001, p. 102), despite being considered an integral part of the consultation that can improve nurse-patient collaboration (Dunn, 1993b; McCreaddie et al., 2010), decrease social distance between nurse and patient (Coser, 1959; Tanay et al., 2014); reduce patient stress and anxiety (Lefcourt & Martin, 2012; Nezu et al., 1988; Oliffe et al., 2009; Wender, 1996), invite patients to be active participants in their care (McCreaddie et al., 2010; Schultes, 1997), potentially improve the health of patients by indirectly reducing stress and its negative effects (Martin & Lefcourt, 2004) and even reduce malpractice claims (Levinson et al., 1997).

As previously stated, humour is seen as an important aspect of nurse-patient interaction and therefore a large amount of research in the area has been carried out. Despite this, little is known about how humour occurs naturally in consultations, as much of the research is built upon questionnaire data, interviews, surveys and diaries (Åstedt-Kurki et al., 2001; Åstedt-Kurki & Liukkonen, 1994; Ghaffari et al., 2015; Granek-Catarivas et al., 2005; Haydon & Riet, 2014; Haydon et al., 2015; Ridley et al., 2014). On top of this, research has ignored how patients use humour and focused

solely on the healthcare workers' utterances (Åstedt-Kurki et al., 2001; Bennett, 2003). Furthermore, healthcare studies of humour have largely ignored sociolinguistic theory, pragmatics and conversation analysis, despite the fact that meanings behind communication were analysed. Grainger (2004) goes so far as to say that these studies and their findings are therefore 'naïve' due to a lack of theoretical grounding. This study will view the usage of humour by both interactants from primary data using an interpersonal pragmatics approach, attempting to fill the gap left by previous research.

Although there is a gap in healthcare research in the aforementioned areas, three studies have tackled these issues – Grainger (2004b) and Ragan (1990), and, more recently, Schöpf et al. (2017), which will be discussed in more detail in section 4.5.1. Grainger's study of verbal play in an NHS geriatric acute ward looked at 12 interactions between nurses and patients, whereas Ragan's study of gynaecological exams in a southwestern university in the USA analysed 15 instances of humour between a nurse practitioner and her patients. Both of these studies gathered primary data via audio recordings and used sociolinguistic theories in their analyses. Despite these similarities to my study, both Grainger and Ragan were interested in how humour arises during uncomfortable situations (e.g. the gynaecological exam, bathing and dressing) and did not look at uses of humour that arose before or after them. In my study I will look at all forms of verbal play, not just those that occurred as a result of uncomfortable situations.

4.5.1. *When does Humour Occur and How is it Formed?*

It is anticipated that contextually-bound humour will occur in the dataset rather than structured or planned jokes. Structured jokes are discussed in further detail in section 4.6., but can here be defined as 'context free and reusable' (Hay, 2001, p. 57), such as 'knock knock' jokes. This expectation has arisen due to the findings of a number of researchers (Scholl, 2007; Astedt-Kurki & Luikkonen, 1994; Mallett & A'hern, 1996). Mallett and A'hern's (1996) ethnological research of five patients with renal failure found that canned jokes were not used at all and large amounts of laughter were also rare. They found that humour was often produced as 'spontaneous asides,

which were related to the topic of the conversation' (p. 538), making these attempts at humour contextually bound. Similar findings were discovered by Åstedt-Kurki and Isola (2001) in their study of 16 nurses' diaries. Due to these findings I would assume that structured jokes would not appear frequently in my data, if at all, but that humour would be manifested via small 'asides' during the 'normal' conversation between the nurse and the patient. The research of Olsson et al. (2002) could be seen as supporting this: when they asked patients whether humour was used in healthcare only a small fraction of patients said that it was. Their conclusions suggested that the forms of humour being used were potentially not discernible as such. Similarly, Astedt-Kurki and Liukonnen (1994) found that patients found it difficult to describe the humour that occurred in interactions because it was so 'intricately linked up with the situation' (p.186). I would assume that a comparable finding could arise from my data.

If humour is contextually bound, when is it expected to be used? There is quite a limited amount of research surrounding this question, but one paper, in particular, has discussed the points at which humour occurs. Åstedt-Kurki and Isola (2001) analysed the diaries of 16 nurses, who noted every instance of humour that they remembered during their working day for one week. Astedt-Kurki and Isola disseminated their findings of humour between the nurse and patient into five sections, depending on when humour would arise:

HUMOUR BETWEEN PATIENT AND NURSE

Nurse-based
- Survival-oriented
  - Nurse's mishap in work
  - Nurse's forgetfulness
- Creative goal-oriented
  - Nurse's 'facetious' threat
  - Jocular situation created by nurses
  - Jokes and playfulness

Co-operation-oriented
- Consensus-oriented
  - Funny situations caused by poor senses or other communication problems

Patient-oriented
- Observation-based
  - Patient's witticism
  - Patient's quip
  - Patient's self-irony
  - Patient's 'cheekiness'
- Unintentional situation
  - Patient's forgetfulness
  - Patient's mishaps

(Åstedt-Kurki & Isola, 2001, p. 454)

Figure 4: Astedt-Kurki and Isola's (2001) categories of humour

- Survival-oriented humour – involved mishaps at work (banana-skin situations)
- Creative goal-oriented humour – facetious threats and playful jokes made by nurses to patients
- Consensus oriented humour –humour created through misunderstandings e.g. patient with bad hearing misunderstanding the nurse (usually involved nurse laughing without patient's knowledge, making it non-consensual)
- Patients' observation-based humour – patient using self-mockery or irony
- Unintentional contextual humour – patient forgetfulness or mishap (usually involved nurse laughing without patient's knowledge)

Clearly, this list may be missing some forms of humour due to the diary method of the study; the nurses may have misinterpreted patient-oriented humour or forgotten incidents of laughter/play. These categories of humour have thin definitions, especially 'creative-goal oriented humour', which is labelled as 'jocular situations created by nurses or jokes and playfulness' (ibid. p454). Firstly, this particular definition raises an issue of what is counted as 'playful' and whether the jokes mentioned are contextually bound or canned jokes. Using the extremely limited examples from the article it could be assumed that these 'playful' situations are linked to teasing, jocular mockery and facetious threats, and therefore, this type of humour will be labelled as such in my analysis. Secondly, the definition lists only nurses as initiating this form of humour, seeming to remove any patient involvement, whereas I believe that it will be likely that humour can be introduced by the patient. This will be investigated in my analysis.

When looking at other research in this area, there are similarities in the timing of humour. For example, du Pre (1998), discovered that both healthcare providers and patients would use humour in situations of embarrassment (survival-oriented) and camaraderie (creative goal). However, a key point at which humour arises does seem to have been overlooked in Astedt-Kurki and Isola's study – difficult situations e.g. times of anxiety, pain or discomfort. Humour has been observed to occur during the introduction of difficult topics (Warner 1984), times of pain and anxiety (du Pre 1998, Sumners 1990; Mallett & A'Hern 1996; Grainger, 2004b; Ragan, 1990) and at

times of frustration with health issues and the medical establishment (Wender, 1996).

Despite the limitations of Astedt-Kurki and Isola's framework, it is the most detailed report of when humour arises in healthcare provider-patient interactions. Therefore, these categories do provide a starting point for analysis and understandings of where humour may occur in nurse-patient interactions.

4.5.2. *Functions of Humour/Laughter*

The healthcare literature has identified a number of humour functions. It is important to establish not only when and how humour is invoked, but also its purposes in the interaction. I present the findings from the literature as a table below, based upon the research of Schöpf et al. (2017), who identified ten humour functions in their study of 50 recorded consultations in an Irish diabetes setting. The ten functions are part of the two umbrella categories of relationship protecting humour and relationship building humour. I have added to the work of Schöpf et al. (2017) by providing citations to other research that reports similar findings.

Function	Description	Further evidence of phenomenon
Relationship protecting humour		
Dealing with negative emotions	The humor initiator uses humor to deal with situations that cause negative emotions such as embarrassment, anxiety, or discomfort.	(Chapple & Ziebland, 2004; Moore, 2008; Oliffe et al., 2009; Warner, 1984)
Expressing and softening criticism	The humor initiator expresses criticism or anger with the interlocutor through humor.	(Åstedt-Kurki et al., 2001; du Pré & Beck, 1997; Tanay et al., 2014)
Expressing frustration	The humor initiator expresses frustration or anger with a third party or certain circumstances through humor.	(Olsson et al., 2002)
Rejecting and disagreeing	The humor initiator disagrees with the interlocutor or rejects a suggestion/recommendation through humor.	(McCreaddie & Wiggins, 2008)
Expressing concerns	The humor initiator expresses a concern through humor.	(du Pré & Beck, 1997)
Relationship building humour		

Showing lightheartedness	The humor initiator uses humor to create a lighthearted atmosphere.	(Pryor, 2010; Tanay et al., 2014)
Highlighting familiarity	The humor initiator uses humor to highlight familiarity or to create a sense of familiarity although the interlocutors have not met before.	(Åstedt-Kurki & Isola, 2001; McCreaddie & Payne, 2014; Pryor, 2010; Tremayne, 2014)
Helping interlocutor to deal with negative emotions	The humor initiator uses humor to help the interlocutor to deal with negative emotions.	(Scholl, 2007)
Decreasing the power asymmetry	The humor initiator uses humor to decrease the power asymmetry.	(Dean & Gregory, 2005; Gramling & Gramling, 2012; Scholl, 2007; Sumners, 1990)
Showing solidarity and creating an in-group feeling	The humor initiator uses humor to show solidarity with the interlocutor and to create an in-group feeling between initiator and hearer.	(Bauer, 1999; Mallett & A'hern, 1996; McCreaddie & Payne, 2014; Tanay et al., 2014)

Table 2: Schöpf et al.'s (2017) ten functions of humour with added citations reporting similar findings

Schöpf et al. (2017) found that healthcare providers most frequently dealt with negative emotions via humour (6.1% of all humour events), followed by showing lightheartedness (5.4%) and expressing and softening criticism (5.1%). Patients similarly used humour to deal with negative emotions most often, but to a much higher degree (19.0%), followed by showing ligtheartedness (13.6%) and expressing frustration (11.2%). I expect that my data will reveal somewhat similar results, but the amount of cloaked criticism and expressed frustration may be less, as the majority of my recordings do not involve chronic care, which could have led to the high amount of these forms of humour, especially for patients.

Although this list provides a large number of functions of humour, other research has suggested that there may be even more than those listed above. McCreaddie and Wiggins (2009) suggest that patients use humour to construct a 'good patient persona', the sum of compliance, sycophany, positive coping and displaced concern, to varying degrees (p. 336). Patients use what McCreaddie and Wiggins call problematic and non-problematic humour – umbrella terms that are similar to relationship protecting humour and relationship building humour, respectively – to mitigate potentially threatening concerns and criticisms, or create a bond between the two interlocutors. Tanay et al.'s (2014) research supports the idea of a good patient persona as patients reported that they 'use humour because nurses like patients who have a sense of humour' (p. 1297) and that they want to be liked by nurses.

Another function of humour used specifically by patients in the literature is to create an individual identity. This function has been observed by McCreaddie and Wiggins (2008), DuPre (1998) and Tremayne (2014). I expect some of these functions to be more utilised than others, for example, patients and nurses using humour to cloak embarrassment and fear in order to preserve their own or the others dignity and using it to build rapport and create a more calming environment.

4.6. A Linguistic View of Humour

Humour usage and theory has been an interest of linguists for a number of years, drawing on three main functions: superiority, incongruity and relief. Superiority (Hobbes, 1968) is a kind of schadenfreude – taking pleasure in others' discomfort or misfortune, while Freud's (1960) relief theory posits that humour is used to release nervous energy. Incongruity theory (Bateson 1953, Suls 1972) has gained the most traction with linguists; it sees humour as created through a use of clashing frames and expectations.

Modern theories of humour regard the perception of incongruity as a necessary condition for humour (Norrick, 2009, p. 265), and this can be linked to the pragmatic notion of the Cooperative Principle (Grice, 1975), as by flouting the conversational maxims (section 2.2.2), incongruity arises and humour *can* be generated. It is important to note that incongruity alone does not create humour; it is in-group knowledge combined with incongruity that enables the hearer to establish that an attempt at humour is being made.

Incongruity theory has been widely applied to structured jokes e.g. 'a man walks into a bar' (Davies, 1982; Attardo, 1993). These jokes are not contextually bound and are therefore reusable (Douglas, 1968). Moreover, a structured joke 'is likely to disrupt a "normal" or "serious" conversation' (Chiaro, 1992, p. 114) as it is typically cued via highly formalised introductory statements, such as 'have you heard the one about…' (Boxer & Cortés-Conde, 1997). It would not be expected that 'canned' or structured jokes are used within a nurse-patient interaction, but rather conversational and spontaneous forms. This is due to research findings within institutional settings which suggest that humour is highly contextually bound and occurs spontaneously in conversation (Åstedt-Kurki & Liukkonen, 1994; Holmes, 2006).

Despite the focus on canned jokes and joking in the past, a movement towards researching humour more generally has arisen. As Coates (2007, p. 30) states, 'while joking is clearly a part of humour, it is surely the case that humour is a much broader, more fuzzy-edged category than the term "joking" implies'. Views such as this have promoted interest in 'conversational humour', an umbrella term for forms

of verbal play 'created spontaneously or repeated verbatim for the sake of amusing the recipient' (Dynel, 2009, p. 1286). This verbal play occurs in everyday conversation and is typically contextually bound.

Conversational humour can be broken down into a number of forms, a list of which includes the items below (for a more detailed review of conversational humour forms please see Dynel, 2009):

- Teasing – Conversational joking is 'directed at someone present' (Boxer & Cortés-Conde, 1997, p. 279) and 'runs along a continuum of bonding to nipping to biting' (ibid.) Due to this it can result in both face threat and face support (Bousfield, 2008; Dynel, 2008) (see section 4.6.1).
- Banter – Teasing can develop into banter when the interactants rapidly exchange humorous retorts along a common theme (Norrick, 1993, p. 23).
- Sarcasm – A form of mock politeness that involves politeness strategies that are obviously insincere and that displays social disharmony (Culpeper 1996, p. 356). For example, when someone has made a mess rather than tidying another person may say to them 'you did a great job'.
- Self-denigration – A form of humour in which the speaker targets him/herself by self-teasing (Lampert & Ervin-Tripp 2006) with humorous intent. (see section 4.6.2)
- Joking about an absent other – A rather self-explanatory type of joking, this form of conversational humour does not involve any of the participants in the conversation and typically creates bonds between interlocutors by creating an 'out-group' (Boxer & Cortés-Conde, 1997, p. 283).
- Stock witticisms – Seen by Norrick as humorous recycled phrases, such as idioms, that appear at crucial points in conversation (Norrick, 2009). They occur in 'ongoing conversation without announcement or interruption of its flow [and] should be fairly generally known, if not regularly used, by all members of the linguistic community or peer group in question' (Norrick, 1984, p. 195). An example would be 'I need a slap on the wrist'.
- Language play – This includes a variety of different forms of humour that play with words to create new and humorous meanings.

◊ Lexemes and phrasemes are short humorous words or phrases which are novel either in form or in their use. For example, a lexeme can typically be conceptualised as a neologism which capitalises on word-formation processes (Dynel, 2009, p.1286) e.g. the blending of 'sexual' and 'escapade' to create 'sexcapade'.

◊ Punning involves a word or phrase that can have multiple interpretations. The ambiguity in meaning can lead to the creation of humour by building on the context of the conversation (for more detail on punning see Attardo 1994).

◊ Simile, hyperbole, metaphor and paradox can also be used to create humorous meaning within a conversation.

4.6.1. *Teasing and Potentially Aggressive Humour*

The nursing literature suggests that nurses should avoid instances of aggression whilst attempting humour (Buxman, 2000). Teasing, banter and sarcasm are forms of humour that could portray aggression to the patient by posing a potentially face-threatening act. Despite the potential for aggression, teasing is intended to be understood as humorous or non-threatening (Alberts, 1992; Hay, 2001; Schnurr, 2009) and can be face enhancing (Geyer, 2010). However, Alberts et al. (1996, p.340) argue that these forms of humour often convey truthfulness and that genuine aggression is being disguised by the speaker. In this vein, much research suggests that due to teasing having the potential to 'bite' (Boxer-Cortés-Conde, 1997) it is only used in established relationships or relationships that have a power imbalance (Lampert & Ervin-Tripp, 2006; Sinkeviciute & Dynel, 2017; Straehle, 1993). This further links to the nursing literature as it suggests nurses only use humour that is appropriate to the individual patient's interests (Sumners, 1990; Wender, 1996), therefore an established relationship needs to be in place.

Hay (2000) analysed the conversations of 18 New Zealand friendship groups and revealed that teasing was mostly directed at in-group participants as friends are better equipped to judge whether a tease is free from real aggression. Similar results

were found by Lampert and Ervin-Tripp (2006) in their study of 59 interactions involving friendship groups. However, as Haugh (2011) notes there has been a lack of attention paid to 'biting' humour used between previously unacquainted interlocutors. In his study of conversations between unacquainted Australians, Haugh revealed that teasing was used as 'an important means of establishing connection face' (2011, p. 179). Haugh concluded that these usages of potentially biting forms of humour between unacquainted speakers could reflect an 'Anglo-Australian cultural ethos that emphasises ordinariness, familiarity and friendliness, as well as not taking oneself too seriously' (2011, p. 180). It would be interesting to see whether this form of humour is used between nurses and patients who had never met before and the functions that it plays in these interactions.

As stated previously, teasing has also been attributed to displays of power (e.g. Straehle, 1993). This can again be linked to the nursing literature as it states that nurses should not use humour to exert power (Meyer, 2000). Research into workplace conversational humour has highlighted that those in power can assert their dominance through teasing (e.g. Holmes, 2000; Holmes & Schnurr, 2005; Schnurr, 2009). Schnurr's research of three leaders in a workplace in New Zealand found that they used teasing to assist them in getting things done, criticising subordinates, and reinforcing solidarity, whilst also constructing their professional identities (2009, p. 1127). Holmes (2000), in her study of workplace humour in New Zealand found that leaders used humour and teasing to subtly control the behaviour of their subordinates or to attenuate a criticism. The humour functioned to 'gain willing compliance, while, at least superficially, expressing solidarity and de-emphasising the power differential' (p. 176). Nurses could use humour in this way to gain compliance from their patients and this will be tested in my analysis. A further finding from Holmes' (2000) study was that potentially aggressive forms of humour were also used by subordinates to challenge the institutional power structure. This contestive humour could be used by patients to cloak criticisms of the nurse and the institution itself.

4.6.2. *Self-denigration*

Self-denigration differs from teasing as the speaker is the butt of the humour rather than the listener. This form of humour is often used in troubles-talk to help the speaker deal with a difficult situation. It is likely that self-denigrating humour will occur in nurse-patient interactions as the patients will most likely discuss some (health-related) troubles in the consultations. Self-denigration is argued as a 'relatively 'safe' way of using humour as it is primarily directed towards the speaker's face' (Schnurr & Chan, 2011, p. 21). The speaker simultaneously attacks their own face whilst also saving it by mocking their mistake/failure. Dynel states that this is an 'indication of pre-conceived self-presentation politics and self-assuredness' (2009, p. 1295). Responding to this form of humour may pose a challenge as the 'speaker has conflicting face needs' (Hay, 2001, p. 74). The hearer walks a balancing act between supporting the humour and disagreeing with the negative statement about the speaker. Jefferson (1984) argues that the recipient of troubles-talk would not typically laugh, but give a non-humorous response due to the seriousness of the underlying message in the humour. This could be seen as not supporting the humour, but the speaker's character. However, this could also threaten the speaker's face by not attending to their humour attempt. I will analyse the responses of self-deprication in my data as I would expect the nurses to respond seriously to troubles-talk.

4.6.3. *Framing of Humour*

Conversational humour can be 'spontaneous outbursts of verbal play' (Coates, 2007, p. 31) or it can be more collaborative, invoking a play frame (see section 2.3.4.3). The view of talk as 'play' was introduced by Bateson (1953), who believed that conversations can be broken down into separate frames of serious discourse and playful discourse. Participants jointly construct 'a shared interpretation of what is going on' (Holmes, 2006, p. 27) and are able to transform this 'frame' at any time from serious to playful using 'appropriate cues [from the context] that make it a laughing matter' (Boxer & Cortés-Conde, 1997, p. 277). As stated previously, collaboration is an integral component of a play frame – 'conversational participants

have to recognise that a play frame has been invoked and then have to choose to maintain it' (Coates, 2007, p. 32). Due to the need for collaboration, researchers see a play frame's main purpose as being to build solidarity (ibid.), which I will take into consideration when analysing the recordings and post-interaction interviews.

4.7. **Conclusion**

Overall, this chapter has introduced the literature that will be particularly relevant in my analysis chapters. It has outlined typical structures of healthcare interactions, which will provide a basis for my analysis and enable me to gain insight into the joint management of the consultation. The research on openings and closings has highlighted common features that may, or may not, occur in my data, allowing me to draw comparisons with previous findings. My review of requests has underlined the framework that will be applied to my data and suggested common forms of requests within this setting. Finally, the study of humour has highlighted potential forms and functions that could appear in my data.

CHAPTER 5

5. METHODOLOGY

5.1. Introduction

This study takes an ethnographic approach to nurse-patient interactions, looking at 100 audio-recordings and interviews reflecting on the recorded consultations. It aims to cast light on the nature of nurse-patient interactions in GP surgeries and gain an understanding of how speech and paralinguistic features are perceived by both caregiver and receiver. This will be achieved by a triangulation of data collection methods: audio-recordings of consultations and post-consultation interviews. The analysis will consist of both qualitative and quantitative approaches, combining both inductive and deductive modes of analysis through using the pragmatic theories of politeness and relational work to account for observations and then assessing these theories through amount of usage in the data. A pragmatic approach was chosen as it takes into consideration that 'aspects of meaning…cannot be predicted by linguistic knowledge alone and takes into account knowledge about the physical and social world' (Peccei, 1999, p. 2). This approach enables the researcher to tie linguistic theories to real-world usages and bear in mind the perceptions and agendas of the users of the linguistic features in question.

This chapter will begin by outlining a number of potential data collection methods and supporting the reasons behind the chosen ones. This includes interview design and questions in section 5.2.4.1. and 5.2.4.2. respectively. Section 5.3. notes the setting of the study and is followed by the sampling strategy and data collection procedures. This section includes the inclusion and exclusion criteria for the participants. Ethical considerations are highlighted in section 5.5. Following this are discussions of how the data was processed and analysed. These sections are broken down into initial data analysis, openings and closings, request and humour data analysis. The conclusion follows in section 5.8.

5.2. Data Collection Methods and Approach

It has been noted that there is a 'necessity for empirical investigations to be produced in a wide variety of health care contexts' (Mullany, 2009, p. 1). A review of palliative care studies discovered that only a fifth of research between 1990 and 1999 used qualitative methods (Bailey et al., 2002). The majority of these studies have been carried out using surveys, interviews and simulated interactions rather than gathering authentic data from consultations (Breeze & Repper, 1998; Haugan et al., 2013; McCabe, 2004; O'Hagan et al., 2014; van der Cingel, 2011). Not only is there a lack of authentic data being recorded, but if there is, the respective studies were carried out in other countries with different healthcare systems and practices than those in the UK (e.g. Mann et al. (2001) - US and Canada; Macdonald et al. (2013) – New Zealand; Kettunen et al. (2002)– Finland). The benefits of qualitative methods have frequently been discussed in healthcare research (e.g. Britten (1995); Bryman et al. (1988); Walshe et al. (2012)) as they '[seek] to represent experience…from the actor's perspective, and [seem] to offer us a more intimate picture of the people and situations of caring practice' (Bailey et al., 2002, p. 49).

This chapter will review a number of ways in which one could study nurse-patient communication, showing the advantages and disadvantages of each, whilst doing this, it will highlight the reasons for choosing the current methodology and the insights that it can afford.

5.2.1. *Visual*

Video-recording of medical consultations can provide richer data compared to other observational methods (Inui & Carter, 1985). It is common knowledge that communication consists of both verbal and non-verbal acts that are 'completely interwoven in interactional behaviours' (Bavelas & Chovil, 2000, p. 164).

One of the greatest concerns about video recording is that it may modify the participants' behaviour and that it could lead to introspection and self-doubt in the minds of the researched, therefore leading to distorted results (Mays & Pope, 1995). However, research has shown that modified, or camera-related, behaviours typically end in the very early stages of interaction (Penner et al., 2007) and the vast majority of patients (75-95%) when interviewed after video-recording stated that they were either only slightly or not at all influenced by the recording.

Despite this, it has been reported that patients felt discomfort at the prospect of recorded consultations and were unsure of being able to discuss private issues with the healthcare provider. This contrasted with anticipation of patients who were to be audio-recorded; they expressed comfort and were not worried about inhibited speech (Bain & Mackay, 1995) . These types of recording also require a more structured observational format (Walshe et al., 2012) as the camera needs to be placed in the optimal position and is then difficult to relocate. The study that I am undertaking requires freedom of movement as consultations will be recorded in different nurses' offices, within different practices and patient interviews will be carried out immediately after the consultation. It would not be possible within the budget to place cameras in all of these rooms and manoeuvrability within this study is key.

It has also been noted that video-recordings are more intrusive and reactive (Penner et al., 2007; Walshe et al., 2012). Due to this, gaining ethical consent to video-record is more difficult than gaining audio access.

5.2.2. *Audio*

Audio-recording was chosen as the primary method of data-collection as similar to video-recording it provides the researcher with rich, authentic data. By observing and recording interactions researchers can:

> overcome the discrepancy between what people say and what they
> actually do. It circumvents the biases inherent in the accounts
> people give of their actions caused by factors such as the wish to

present themselves in a good light, differences in recall, selectivity,
and the influences of the roles they occupy.

(Mays & Pope, 1995, p. 183)

Audio recording is, as previously stated, less intrusive than video and enables the researcher to completely focus on non-speech data (Walshe et al., 2012) via note-taking. A static video could miss some paralinguistic features that could be key to meaning and understanding if they occurred outside of the video camera's view. Note-taking would enable the researcher to concentrate on movements from both participants and the researcher can adjust her position in order to capture everything that occurs.

A further reason for adopting the method of audio-recordings is that they have been deemed to have less influence over participants than video. Knox et al. (2002) found that 97% of patients admitted post-recording that their behaviour had not been modified and they discussed problems with their physician as normal.

5.2.3. *Surveys*

A survey was not adopted for this study as participants can often find it difficult to remember the exact words they use in consultations and may skew results by answering questions how they think they should be answered (Walshe et al., 2012). An example is the research carried out by Fitzpatrick and Hopkins (1983) who found that patients had a reluctance 'to express critical comments about their healthcare' (1983, p. 117) in the NHS. Backhouse and Brown (2000) and Delbanco (1996) support this finding, as they state that survey results often paint a falsely positive picture.

Surveys also need to be extremely well-designed to get the anticipated results. Participants can rush through questionnaires and miss important parts of questions or simply answer them incorrectly due to bad wording or misinterpretation. Fitzpatrick argues the 'more specific and well designed the questionnaire, the clearer it is that patients do not respond in terms of global reactions' (1991, p. 888).

Furthermore, data collected from questionnaires is not as rich, and although a larger number of results could be collected, it would not suit linguistic analysis.

5.2.4. *Interviews*

The second type of data collection used in my study was the interview. A triangulation of methods was used, as when observation and interview are combined they can be 'complementary instruments' (Gorden, 1969, p. 56). Triangulation has also been suggested to improve the validity of qualitative research (Pope et al., 2000). Ford et al. (1996) and Tasso et al. (2002) noted that observations and interviews provide a clearer picture of patients' understandings and a deeper exploration of what influences patient satisfaction in a consultation.

The interview, in this case, is used as 'an evaluative tool' (Gorden, 1969, p. 56) following the observation. This allows me to collect more information on how the patients and nurses understood the consultation, taking into account both perspectives of the consultation and their evaluations of the language used throughout. Interviews are seen as a 'dynamic, content- and respondent-sensitive procedure' (Kasper, 2000, p. 332) and were chosen due to these reasons.

5.2.4.1. *Interview Design*

A well-designed interview was integral to my study. Due to the interview following the recording and observation I opted to use a semi-structured interview as many of my questions would be based upon the participants' thoughts and feelings of what had just occurred in the consultation. Semi-structured interviews have a loose format that consists of open-ended questions that surround the area of exploration. The 'interviewer and interviewee may diverge [from the topic] in order to pursue an idea in more detail' (Britten, 1995, p. 251).

It is important in research interviews for the researcher to remain unbiased by not imposing assumptions or hypotheses on the interviewee. The researcher must also be willing to accept that what may emerge contradicts their previous predictions (Britten, 1995). Interviewers must ensure that they check their understandings of what the participant has said and remain sensitive to the language used by interviewees. Webb (1992) constructs the qualitative interview as a conversation in that there is an information exchange and the interview should remain interactive.

5.2.4.2. *Interview Questions*

I asked a set of loose questions that led to the patient's understandings of the consultation. The questions were open-ended so that the topic could be explored and, if necessary, ideas could be pursued in more detail. The loose format of interview questions for the research was as follows:

1. How do you feel the consultation went?

This question was asked to ease the participant into the interview process as it is 'best to start with questions that the interviewee can answer easily and then proceed to more difficult or sensitive topics' (Britten, 1995, p. 252). It was expected that the interviewee would hopefully discuss whether the consultation was a positive or negative experience and details of why could be followed up on. Politeness involves considering and being aware of one another's feelings so this question was both simple to answer and befitting the research.

2. How did you find the communication between yourself and the nurse?

This question was used to lead to specific examples of when the communication was perceived positively or negatively from the patient's perspective.

3. What, if any, were good things from the consultation?

This question was asked if no positive features were highlighted within the previous question and provided an insight into language that was deemed respectful and 'polite' from a nurse.

4. What, if any, were bad things from the consultation?

Similar to question 3 this question was asked if no negative features were mentioned in regard to question 2. It aimed to elicit language that was not seen as polite in the interaction.

5. How did you find the nurse's manner?

Question 5 aimed to determine how the patient felt about the nurse's approach to the consultation. The patient could discuss paralinguistic features here or whether they felt as though the nurse was rushing or potentially taking a 'task-centred approach'.

6. What do you see as important aspects of nursing communication?
7. Thinking generally, what makes you satisfied with a consultation?
8. Thinking generally, what might make you dissatisfied with a consultation?

The last three questions were more general so as to determine what is seen as positive and negative behaviour and language in all nurse-patient interactions. This allowed patients to bring up issues that were not raised in previous questions as they were directed only at the consultation that had just taken place. Questions such as these were included as they could have highlighted potential issues that patients may have generally or certain behaviours that make them feel at ease.

5.2.5. *Consultation Notes*

As previously stated non-verbal behaviour accounts for 55-97% of a communicated message (Gross, 1990), hence it was vital to record both linguistic and non-linguistic strategies. Although a relatively new aspect of politeness research, non-verbal regularities have been found in the use of politeness strategies (e.g. Nakano et al. 2003, Rehm & Andre 2005, Trees & Manusov 1998,) to minimise face threat. Moreover, they are used to build rapport and convey warmth and support (Bensing et al., 1995) which is key in nurse-patient relationships.

It was clear that during the consultations not all prosodic and non-verbal behaviours could be recorded, therefore it was important to clearly distinguish before data

collection the most potentially meaningful behaviours to be documented. Heintzman et al. (1993) identify five non-verbal behaviours that are essential in rapport building:

1. Eye gaze – Bensing et al. (1995) claim that the amount of patient-directed gaze has an impact on the patients' communication in that these two things are positively related. It has also been noted by Drew (1986) that patients felt excluded by nurses who avoided eye contact. It would not be possible to note down all movements of the patient's and the nurse's eyes, but notes will be made when eye gaze is held or avoided, and when utterances that could be potentially face threatening (such as requests) are made.

2. Head nodding – Head nods are associated with being caring and concerned (Heintzman et al., 1993), whilst also encouraging talk from patients (Caris-Verhallen et al., 1999). All forms of nodding or head shaking will be recorded and time stamped.

3. Smiling – Smiling is also seen as encouraging and supports rapport building (Heintzman et al., 1993). It has also been noted that smiling helps to mitigate face-threatening acts (Trees & Manusov, 1998). From this, smiling will be noted down when possible, but extra care will be taken when it corresponds with potential face threatening acts.

4. Body positioning – A more direct body orientation has also been found to help mitigate FTAs (Trees & Manusov, 1998), whilst also showing attention and involvement (Gross, 1990). If the nurse or patient shows movement of their body to support their language, this will be noted down. For example, if the patient shows disinterest linguistically, via prosody or averting gaze and their body slumps, a note will be made.

5. Touch – Touch will inevitably be a part of a nurse-patient consultation and there are two types of touch that are of interest (Hollinger & Buschmann, 1993):

    a. Instrumental touch – a nursing intervention touch that is necessary for the purpose of the consultation. This has been found to be the most common form of touch, appearing in 95.3% of interactions (McCann & McKenna, 1993). This will be noted as necessary to describe what is occurring in the consultation.

b. Expressive touch – used to communicate empathy or comfort, 'it is related to affective verbal communication, meaning that as the nurse shows empathy and concern during encounters she also expresses this by touching the patient' (Caris-Verhallen et al., 1999, p. 815). It was found in this study to be quite a personal attribute that belonged to an individual's communication style. Once again, all behaviours of this form will be noted as this could provide an insight into individual usages of politeness.

Heintzman et al. (1995) do not discuss gesture, prosody or propositional silence (Ephratt, 2008) in their discussion of non-verbal behaviours, all of which can hold meaning. Lomax (1996) found that silence can be used to promote acceptance, concern and support for the patient. The researcher in this study will make note of any notable periods of silence that could convey meaning, while the recording will show any interesting features in tone or pitch. Prosody could potentially be important, as O'Hagan et al. (2014) found that nurses were regarded negatively when their tone suggested disinterest. Laplante and Ambady (2003), in a study of perceptions of politeness, found that appropriate prosodic cues lead to correct understandings of utterances.

Finally, gestures will be noted when matched with potentially face-threatening linguistic utterances, as Rehm and André (2005) have found that 'gestures play a principled role in the realization of [politeness] strategies' (p.144) when analysing student criticisms of one another.

5.3. Setting

The study recruited nurses and patients from two North-West GP surgeries in the same town, which will not be named due to ethical and privacy issues. I chose to study GP surgeries, as they are the first port of call for patients with routine and minor illnesses. There has been an array of studies looking at the language of nurses in palliative care and hospital settings (e.g. Iedema, 2005; Graham, 2009; Marsden & Holmes, 2014; Staples, 2015), but GP surgeries and, specifically, GP nurses have

been under-researched despite their role 'permeat[ing] the entire range of patients' experience with the clinic' (Poulton, 1996, p. 26). Care in a GP surgery is also centred around 'continuity of care' (Boddy, 1975, p. 1) and this leads to a growing relationship between the healthcare workers and their patients. These relationships are known to affect the nature of medical care (Britten et al., 2000), highlighting that rapport and language use are a key factor in nurse-patient consultations and research in this area is of great importance.

The setting was chosen for both practical and convenient purposes. The aging population of the town allowed for a strong likelihood of gaining a large amount of older patients ensuring that the nurses had experience speaking to an older generation of patients. This would allow the researcher to draw comparisons between the language used with younger and older patients, enabling a thorough test of the claim that nurses use patronising language with older patients. The convenient reasons for the setting were that the researcher had previous links to the practices and the local clinical commissioning group (CCG). The collection of data took place between July and December 2015 – this period included recruitment, audio-recording and post-recording interviews.

5.4. Sampling Strategy and Data Collection Procedures

A total of five GP surgeries were asked to take part in the study. The researcher conducted meetings with the practice managers who would then bring up the topic in a doctors' meeting. The first two that responded positively were chosen and the relevant paperwork for the sites was sent to the local CCG. Upon approval of the study from the CCG, nurse and patient recruitment could begin.

All nurses within the practices that had hours with patients in the clinic were asked to consider participation. The nurses were approached during practice meetings or private meetings in their free time. The participation rate for nurses in Practice 1 was extremely high with all of the six nurses agreeing to take part in the study, whereas two of the six nurses in the second practice did not want to take part. All of the nurses had a period of consideration of over 24 hours and were asked to fill out a

consent form after reading the information sheet about the study and asking the researcher questions. The nurses and the practice were informed of the inclusion and exclusion criteria for patients so that the patient consent forms and information sheets could be distributed without researcher involvement and access to patient names.

Envelopes that contained patient information sheets, patient reply forms and a self-addressed, stamped envelope with the chief investigator's PO box attached were given to the nurses and GP reception desks.

Patients were recruited in two ways:

a.   The nurses handed out the envelopes (given to them at the aforementioned meeting) to patients that needed another appointment within the next 4 weeks. The nurses then made a note that the patient had received the information.

b.   The surgery posted the envelopes to patients that were due to have an appointment in a month's time. This was part of standard communication and was included with papers sent by the practice. The patient information sheet, patient reply form and a self-addressed, stamped envelope with the chief investigator's PO box attached were included in this package. Due to ethical issues, the reception of the GP practice would send the envelopes to the patients and address them. The reception would then make a note that the patient had received the information.

The purpose of this was to give the patients enough time to consider their involvement in the study whilst also ensuring they would return to the practice shortly.

Upon receiving their information sheets and consent forms the patients could then return the reply slip via post or email with their names and information about their next appointment. It was a possibility that some patients may forget about the study before their consultation. Therefore, when the patient came in for their appointment the reception would remind them of the study and provided them with extra copies of the information sheet and consent form.

In order to collect the data the investigator was at the GP practice before the consultation, met the patient and signed the consent forms with them. The investigator and patient then attended the appointment and the CI audio-recorded the interaction, making notes on any paralinguistic features (e.g. smile, touch etc.). The CI did not disrupt the consultation in any way, unless:

a. The participants appeared to be distressed. In this case, the CI would ask if the recording may continue and, if not, leave the room and delete anything that had been recorded.

b. As the chief investigator and only data collector it is possible that I could have witnessed poor practice. However, I am not clinically qualified and am analysing the data from the perspective of a linguist, thereby not evaluating practices. I am unaware of what would be deemed as poor practice from a clinical perspective. In the extremely unlikely event that poor practice was witnessed, that could be argued as such by a lay person, such as physical or emotional abuse, I would have reported this to the manager of the practice.

Once the consultation was complete, the CI asked the patient to briefly discuss their thoughts and feelings in a separate room for an interview. The interview was held in a spare room within the surgery (which had already been discussed with the practice manager) and lasted approximately 5 to 10 minutes.

It was integral to the study that the researcher recorded 5 interactions with younger patients for each nurse and 5 interactions with older patients in order to have an equal distribution of older patients and younger patients in the data. This would allow me to thoroughly tackle the research question of 'Is there a difference between how nurses talk to younger patients and older patients?' as the language use could be directly compared.

5.4.1. *Inclusion and Exclusion Criteria*

5.4.1.1. *Nurses*

The inclusion criteria for the nurses was as follows:

- Qualified nurses
- Nurses who work in the GP practices involved in the study and have hours working within the clinic
- Those willing to have their interactions recorded
- Native speakers of English

The only nurses excluded from the study were district nurses who did not have hours within the clinic.

5.4.1.2. *Patients*

5.4.1.2.1. *Younger Patients*

The younger patient inclusion criteria included:

- People aged over 18 and under 46
- People with the capacity to give consent
- Patients who are going to attend any consultation with a nurse within the timescale of my study
- Native speakers of English

The exclusion criteria for younger patients were people younger than 18, non-native English speakers as nurses can speak differently to patients who have English as their second language, those that were not able to consent for themselves and people over the age of 45. The maximum age for younger patients was 45 as mid-life is generally perceived to start at this age (as stated in the Diagnostic and Statistical Manual (1994))

The inclusion criteria for older patients were the same for younger patients, but the age range was from 65 onwards. A gap of 20 years between the ages of younger patients and older patients was decided upon to clearly distinguish these age groups and to limit dilution of potential differences.

Exclusion criteria were the same for younger patients, but there was no maximum age.

5.5. Ethical Issues

The study was designed to accommodate strict NHS ethical requirements and as patients and NHS staff were involved, the online Integrated Research Application System (IRAS) was used to apply for research ethics and governance approval. The application reference is 15/NW/0206 and details of the study can be found on the Health Research Authority website at http://www.hra.nhs.uk/news/research-summaries/a-linguistic-analysis-of-nurse-patient-interaction/. Due to the strict requirements, all paperwork for the study had to be approved in advance and all potential confidentiality and ethical issues had to be raised, along with strategies to deal with these problems.

The main ethical issues within this study were patient confidentiality and satisfaction with the study. As I was recording nurse-patient interactions some people may have deemed this uncomfortable and may have become upset. I aimed to minimise this risk, however, by gaining informed consent and telling participants that they could leave the study at any point. If they were visibly uncomfortable and upset while I was recording I would have deleted the recording and exited the consultation room. However, this was not necessary as all patients within the study were comfortable with my presence.

In order to achieve patient confidentiality I did not initiate contact with them, this was done by the nursing staff and the reception via letters. Once the patients consented to the study via communicating with myself via email or letter, I then

accompanied them from the GP surgery to their health consultation and audio recorded the interaction. The recorded data was encrypted onto my computer and the recorder was stored in a locked cupboard. Upon transcribing the data all names were anonymised and the data was made completely anonymous.

As I was also carrying out interviews at the GP practice, a lone worker policy had to be followed. I complied with the Lancaster University Safety in Fieldwork policy, which can be found at: http://www.lancaster.ac.uk/depts/safety/files/Fieldwork.pdf

A final ethical consideration was the removal of the term politeness from the title and information sheets given to all participants in the study. The reason for this was that a lay person may have different understandings of politeness to a linguist and could therefore change their behaviour by possibly including words and phrases that they understood to be polite. A change in behaviour could have completely altered the results of my study and so I avoided using this term in all public information.

The application and related ethical approvals can be found in the appendices on the CD Rom that was submitted with this document. They were not included in the body as they included potentially sensitive information. If you would like further information regarding the ethical approvals of this study, please contact me at michaelalunan@gmail.com

5.6. **Data Processing**

The data was transcribed using the Jefferson Transcription System (Jefferson, 2004). This method was chosen as it is commonly employed by conversation analysts due to its detailed prosodic transcription. The words that are used are transcribed, but also increases in pitch, elongation of sounds and stress are noted and these paralinguistic features hold meaning in conversation (see transcription key appendix 1). A copy of one of the transcripts can be found in appendix 3.

5.7. Data Analysis

5.7.1. *Initial Data Analysis*

The purpose behind analysing these data was to find language use that fell into the category of interpersonal pragmatics and politeness. A literature review of relational work, politeness and pragmatics was carried out to form a basis of understanding within these fields and enabled me to successfully identify them within the data. My previous research also played a key part in the identification of features as my 2010 and 2012 studies suggested that requests, openings and closings, and giving information were key aspects of the interaction and contained a number of linguistic features that could build or potentially undermine rapport. Using my previous research and theoretical perspectives from the literature review, I carried out an explorative qualitative analysis of twelve individual transcripts. It was decided that twelve recordings would be used for initial analysis – three younger patients and three older patients with two nurses. I assumed that differences in the use of language with older patients would begin to show and by looking at six recordings for each nurse, their individual practices might be highlighted. The two nurses were chosen due to practical reasons: these nurses had already completed the recording process and the transcriptions for each patient were finished. The patients were chosen at random.

The theoretical perspectives (such as Brown & Levinson 1987 and Leech 1983) that I held led the analysis, but I remained open-minded to features that were not in the literature and that could have had an impact on the relationship between the nurse and the patient. Upon highlighting consistent features within each individual transcript, aspects that were surprisingly common or absent within all twelve of the transcripts were noted and collated. These features were then evaluated to find potential relationships and to build thematic categories that would eventually be separated into over-arching sections in the thesis; this was done by developing and relating the identified themes to concepts within the health communication literature as well as the politeness literature. The recurrent conversational and pragmatic features were as follows:

- Openings and closings were chosen due to the recent issues highlighted in the twitter campaign #hellomynameis. Patients feel disempowered when they do not know the name of the healthcare professional they are dealing with and strikingly, neither of the nurses in any of the pilot transcriptions introduced themselves. Closings were chosen as a topic for analysis due to the pilot data findings that, similar to openings, closings were not as ritualised as I would have expected, with a number of consultations not ending with an utterance of goodbye. The linguistic choices of the nurses to suggest an ending to the appointment were also intriguing as, typically, simple discourse markers were used to hint at a closing – in no interactions did the nurse explicitly tell the patient the appointment had concluded, which could suggest politeness usage via breaking the maxim of manner. Interestingly patients also did not offer thanks to the nurses in 5 of the 12 interactions, which was unexpected as thanks are often given during conversational closings in Britain (Aston, 1995).

- Task-oriented talk was selected as an analytical category as it relates to the central activity of the event. Ways in which a nurse transfers information and uses requests will be analysed. The task-oriented language of the nurses and the patients whilst taking blood involved a number of mitigating devices in order to diffuse the situation. The process of giving information from the nurses was filled with hedges, potentially used as face-management devices for the institution or themselves (Bonnefon & Villejoubert, 2006). Finally, requests, especially when linked to the procedure, were not typically mitigated and patterns in usage suggested individual styles.

- The final chapter will address humour within the interactions. A surprisingly large amount of social talk was found in the initial analysis, despite the claim that medical discourse is typically 'task-oriented' (Hewison, 1995). I will focus on humour by looking at how it is introduced, who introduces it and why in order to gain an insight into the nature of nurse-patient social discourse and how rapport can be built.

5.7.2. *Final Data Analysis*

The data for my thesis was, at first, transcribed using Jefferson's (2004) transcription system, discussed above. The data was then divided into the phases of interaction, based on previous research (Byrne & Long, 1976; Heritage & Maynard, 2006; Northouse & Northouse, 1992; Staples, 2015). These phases were similar to Northouse and Northouse's three-phase sequence as the consultations varied in purpose, but all contained these three basic stages:

1. Opening
2. Task-oriented discourse (similar to Staples' (2015) examination phase
3. Closing

The first section, consists of the opening of the interaction e.g. greetings and 'how are you' requests (where they did not receive responses relating to the patient's health). The beginning of the consultation ends when the patient or nurse refers to the purpose of the consultation or discusses health issues. The next section is categorised as transactional discourse and consists of all discourse related to health and the purpose of the consultation, including physical examinations. It may also include small talk that occurs during this process. Finally, the end of the consultation consists of the closing of the interaction, typically signalled by a discourse marker, e.g. 'right', that signifies the end of the medical process and involves patient and nurse partings. My coding led to fewer phases than previous studies (e.g. Byrne & Long, 1976; Staples, 2015; ten Have, 1989), this was most likely due to the large number of transactional appointments that did not include a complaint phase or a counsel phase (Staples, 2015). For example, a blood test appointment did not include patient's raising health complaints or nurses providing counsel about the patient's condition. The follow-up information within these encounters was almost always introduced in the closing phase. Some of the consultations could have been divided further, especially health review interactions, but this was beyond the scope of this study, as I wanted to identify the key phases to aid the discussion of findings. The following table shows the types of visit included in my data. Table 1 in Appendix 2 shows a breakdown of the patient and nurse information including gender, age,

frequency of visit, purpose of visit and length of consultation to the nearest five seconds.

Table 3: The types of visits within my data and the number of interactions of each type

Type of visit	Purpose of Visit	Number of Patients
Transactional	Bloods	40 (53%)
	ECG	1 (1%)
	Cold	3 (4%)
	Vaccination	4 (5%)
	B-12	9 (12%)
	Blood Pressure	2 (3%)
	Contraception	2 (3%)
	Wound dressing	4 (5%)
	Aches and pains	11 (14%)
Total		**76**
Health review	Diabetic Review	13 (54%)
	Asthma Review or test	11 (46%)
Total		**24**

The following sections will discuss the ways in which I analysed data for each of my chapters.

5.7.2.1. *Openings and Closings*

As highlighted in the previous section my transcripts were divided into three phases of interaction. In order to uncover the boundaries of the opening phase, I studied the literature on openings within healthcare interactions (Coupland et al., 1994; Heath, 1981) and applied their structures of doctor-patient openings to my own data (these structures are discussed in section 4.3.1). A brief summary of Coupland et al.'s (1994) structure is listed below:

- summons/approach
- greetings
- dispositional talk
- familiarity sequence

- holding sequence
- how are you? - type exchange

I found a number of the features lacking, which I will discuss in my analysis chapter below (chapter 6), but this structure helped me to code the phases of the consultations accordingly. The opening phase closed when the patient or the nurse oriented towards the task at hand and started to discuss health issues, patient history or introduced the physical examination process.

A similar approach was taken to identify the closing phase of the interaction. The literature on healthcare closings was used to identify pre-closings (Schegloff & Sacks, 1973). West (2006), White et al. (1997) and Heath (1986) identified summaries and arrangements for future contact as common pre-closings of interactions and I used these findings to support my identification of potential pre-closings. Similar to the findings of West (2006) pre-closings did not always initiate the ending of the consultation; however, I understood these turns to start the closing process and then identified further pre-closings or referrals to the initial pre-closing.

The closings typically ended with a terminal exchange (Robinson, 2001) which I labelled as partings; these were commonly followed by thanks, differing from the pilot findings.

5.7.2.2. *Requests*

Requests were identified primarily according to Searle's (1969) felicity conditions (outlined in section 2.2.1), whilst also using the breakdown of features of requests listed by Culpeper and Archer (2008, pp. 47-48). Similar to Searle, I understood directives and requests to be versions of the same action (Searle, 1979, p. 8), understanding that speech acts can be 'fuzzy, complex concepts' (Culpeper & Archer, 2008, p. 47) that can often blur into one another. The identification of requests was not a straightforward task as off-record requests or hints are 'not linked

to any specific linguistic or grammatical forms' (Ogiermann, 2015, p. 31) and so a variety of strategies were used to identify requests:

- The hearer's response – did the hearer perform the act that was suggested by the speaker? For example, in transcript 40 the nurse states 'right arm' and the patient presented it to the nurse.

- Native speaker intuition – due to being a native speaker of English and being present in the interactions I was able to identify directives that had no formal traces of being such.

- Even if the hearer did not perform the act, the context of the talk could define whether the speaker's intention was for the hearer to do something. For example, there were a number of situations where there was no verbal request: in transcript 34, after the patient has breathed into a spirometry machine for the first time, the nurse utters 'ok' with rising intonation as a suggestion for the patient to repeat the process, although the patient did not immediately perform the act, the utterance was classed as a request, as the nurse later repeated the discourse marker and the patient questioned 'again?' and began to breathe into the tube.

A selection of requests in their context was checked by colleagues to ensure correct identification and when there was too much doubt about whether an utterance involved a request, it was disregarded. Upon identifying requests I coded them according to Aijmer's (1996) framework, but added a few categorizations that appeared frequently in my data. These included:

- Clipped forms e.g. Transcript 23 'N: Nice and still'
  Similar to Culpeper and Archer (2008), I found a number of requests that were grammatically elliptical. Although Aijmer (1996, p. 183) identifies forms like this to be elliptical imperatives that occur in routinised situations, it was not always clear whether the request took the form of an imperative.

- No verbal request (as above)

- 'Let us' e.g. Transcript 52 'N: Let's just look at your throat'.
  These requests could have been identified as permission requests according to Aijmer's framework. However, Aijmer does not discuss any 'let's'

requests and these were surprisingly frequent in my data so I wanted to differentiate them.

Upon coding the requests it became obvious that there were differences in the requests according to the phase of the consultation, similar to the findings of Mulholland (1994). There were differences in whether the requests required immediate action or for the action to be completed in the future, away from the consultation setting, therefore requests were organised into procedural requests and follow-up requests. Finally, a further difference was noted in the usage of requests at the opening of the consultation and so these were categorised as opening sequence requests.

5.7.2.3. *Humour and Verbal Play*

The data for this section was coded into serious and playful utterances. Although Norrick (1996) argues that joking and laughter are adjacency pairs, laughter is not always a given response to attempts at humour (Drew, 1987; Everts, 2003; Jefferson, 1979) and so laughter could not be used as the only indication of verbal play. It must be noted that identifying examples of humour was rather complex and subjective, so the approach of Holmes and Hay (1997) was adopted in looking for cues of the speaker's intention. They argue that the speaker signals that they are entering a play frame in a number of ways – via tone of voice, the preceding discourse, a change in pitch, paralinguistic cues and the use of a smiling voice (p. 132). The recordings were analysed for initial speaker cues along with, importantly, respondent cues of laughter, (partial) repetition, elaboration and accord (Drew, 1987). Holmes and Hay's data was purely verbal, whereas my data included researcher's notes on paralinguistic elements. This meant that I could also use facial expressions and body language as cues of a play frame – these included things like smiling and playful hitting. This methodology of looking at speaker and respondent cues to humour proved successful and when in doubt I used a similar approach to Everts (2003) by drawing upon my intuition and asking colleagues' opinions for further confirmation.

Unlike the study of Ragan (1990), play was seen as both single playful asides and collaboratively achieved talk that involved invitation and uptake by both

participants. Ragan did not see single turns with shared laughter as play, but rather sequences where 'both participants displayed an orientation to the conversation as being engaged in playful activity' (p.73), i.e. the respondent must further or appreciate the speaker's attempt at levity. Ragan's definition of play was used in my study as a playful frame. This meant that a frame was created when collaborative humour arose, but not when a single humorous aside occurred. Once a playful frame was invoked I then classed any subsequent verbal play as a return to the play frame as talk can switch frequently and immediately from serious to play once a play frame has been introduced (Bateson, 1953; Coates, 2007). Spontaneous bursts of verbal play that were not collaborative were not discounted as in other studies (Ragan, 1990), but were simply coded separately: these attempts at play could hold important information and the lack of collaboration could suggest social distance and potential issues with the interaction as a whole.

Upon the completion of frame coding I selected texts to use as examples based on how clear the examples were. If there was a large number of transcripts with clear examples, one was chosen at random to be discussed at length.

5.8. Conclusion

Chapter 5 introduced the design, collection and data analysis methods of this study. I argued the reasoning behind audio-recording and the supporting data of post-consultation interviews. I explained the sampling and data collection process in detail and how I ensured patient and nurse anonymity in this sensitive setting. Finally, the ways in which data was analysed were introduced, in general, for initial analysis and for each of the analysis chapters.

CHAPTER 6

6. OPENINGS AND CLOSINGS

6.1. Introduction

As reviewed in section 4.3.1, the first instances of communication between a healthcare worker and a patient can determine whether the relationship blossoms or withers (O'Connor et al., 2011). Unfortunately, research tends to focus on hospital openings/closings, and primary care visits with doctors rather than nurses, leading to a gap in the literature (Coupland et al. 1992, 1994; Robinson & Heritage 2005).

Openings and closings of interactions are reported to include phatic communication: 'free, aimless social intercourse [that] is the first act to establish links of fellowship' (Malinowski, 1936, pp. 313-314). It is typically understood as a form of small talk that usually occurs at the fringes of conversation as relational goals are foregrounded. More specifically, healthcare consultations are believed to open with a 'propriatory sequence' and end with a form of phatic communion that mitigates a 'possible sense of rejection and consolidate[s] a relationship' (Coupland et al. 1992, p. 212). It is for these reasons that openings and closings are a key aspect of healthcare communication as it would be expected that patient-centred communication could occur in these stages.

This chapter aims to gain an understanding of how openings and closings occur in nurse-patient interactions within a GP practice and uncover what forms of communication seem to be the most effective according to the patient interviews. Openings of consultations are discussed in section 6.2. with a focus on summons, greetings and 'how are you' sequences. Closings are the focus of section 6.3., which addresses the following questions: who starts the closing of the interaction, how are closings signalled and how are partings phrased?

6.2. **Openings**

The openings of a consultation can set the tone for the rest of the interaction. They can function to defuse awkward silences (Laver, 1975), to build rapport and to create a shift in 'footing' (Goffman, 1981), i.e. to proceed from relational talk to professional talk. As noted by Coupland et al. (1994), the opening sequence of a primary care visit is, typically, as follows:

- summons/approach
- greetings
- dispositional talk
- familiarity sequence
- holding sequence
- how are you? - type exchange

(discussed in more detail in section 4.3.1)

Despite this, the recorded interactions within my data did not typically involve all or most of these stages, highlighting that the typical opening sequence of doctor-patient interaction differs from that of nurse-patient interactions. The following sections will take a quantitative and qualitative view of these exchange types.

6.2.1. *Summons/approach*

Heath (1981, 1984) notes that consultations with a doctor or nurse are typically opened with a summons (section 4.3.1). In my data, summons involved the calling of a patient's name in various forms and were always followed by the patient accompanying the nurse to the consultation room. Only 71 of these instances were recorded in my data, as in some instances the researcher was in the room already and some calls were inaudible. The use of the patient's name in the summons was typically the only usage throughout the whole interaction and so the terms of address

in these turns were important, as address forms are a noted feature of polite language usage (Brown & Levinson, 1987). As noted by Wood and Kroger (1991, p. 145), 'they…set the tone for the interchanges that follow [and] establish, at least initially, the relative power and distance of speaker and hearer'.

The use of first and second name, and title and second name were the most frequent accounting for 45% and 44% respectively. (The frequencies of name usage can be found in appendix 4). This is most likely due to the summons providing a secondary purpose of securing the patient's identity – a feature which was found to be used separately by doctors in a study by Robinson et al. (1998). An example of this can be seen in the following two transcripts, where the two nurses use the patients' names to summon them into the room, using the response of the patient to the summons as confirmation of their identity (potentially along with the purpose of the consultation).

Extract 4: Transcript 90

1.N: (first and last name) (.) Hi (first name) (.) are you ok? (.) come on in ((P&N walk into room)) (2.2s) alright (.) ok (.) right you've come for an ECG (.) is that right?
2.P: yes (.) that's right (.) yeah

Extract 5: Transcript 11

1.N: Mr (last name) please ((P&N walk into room)) So we're checking kidneys with your blood
2.P: mmmhmmm
3.N: ((gets needle ready (10))) right (.) so is this the best arm is it?

Despite there being a clear preference for last names, there were still a number of instances where the nurse used the patient's first name as a summons. Based upon the literature (McKinstry, 1990; Wood & Kroger, 1993), age and frequency of visit were expected to be factors that determined different forms of address (discussed in more detail in section 4.3.1.2), due to potential patronization and lower social distance respectively.

Despite this expectation, when I examined the terms of address according to patient age there turned out to be no statistically significant difference (Fischer exact test p=0.52). For a descriptive overview of patient terms of address according to age, please see appendix 4.

Looking at the frequencies of title and first name revealed that nurses used this term of address with 37% of younger patients and 50% of older patients. The usage of a title could reflect deference according to Wood and Kroger (1991). Of course, this is only one interpretation and could also be a result of personal style.

Nurses' usage of first names only was the same for both younger and older patients with 11.5% of younger patients and 11% with older patients. Wood and Kroger (1993) and Dowd (1981) argue that due to nurses knowing patients' first names, but patients not knowing the nurse's name there is a one-sidedness of first name usage. This could cause interactional issues and lead to discomfort as some patients, particularly those from an older generation, may see the usage of first name terms as violating their association sociality rights (Spencer-Oatey, 2008) and as a sign of disrespect. An example of first name summons with an older patient can be seen below:

Extract 6: Transcript 13

> 1.N: (first name of P) ((N & P walk into room))
> 2.N: Just the routine bloods (.) isn't it? (1.6) (first name of P) are you alright lovely?
> 3.P: Oh yes (.) yes (P sits down and signs letter of consent) As though there's a spider walked all over it
> 4.N: Oh (.) doesn't matter (3) Perfect

Despite potential violation of association sociality rights, the interviews showed that patients in both age groups actually preferred first name terms and appreciated a more 'informal' approach. For example, patient 42 commented 'it makes you feel old if they use your last name' and patient 13 stated, when asked to expand on how she saw the nurse as 'polite' (her own term), 'she always calls me (first name), which I find makes a difference to Mrs (last name) (said very formally)'.

Finally, frequency of visits was studied and the descriptive overview of this can be found in appendix 4. There were slight differences in percentages in the usage of first and last name with never seen before patients (63% for never seen before patients versus 28% for once or more), whereas patients that had been seen once or more were typically referred to by their title and last name (64%). These differences were not statistically significant, although close with a fischer exact test p value of 0.08. The slight difference could be due to the nurse's ability to recognise the patient, therefore first names may no longer be necessary to differentiate between patients with the same last name. First name usage does seem to be used with all patients although rarely (with 7% used with never seen before patients and 8% with patients seen once or more), despite the nurse having never seen the patient before.

Overall, social distance did show a slight difference in terms of address used as less formality seemed to be used with more frequent patients, although not statistically significant. This could be due to the need to identify the patient via a summons and therefore first names may be used less in opening sequences as clearly identifying the patient is of more importance. This will be discussed in section 6.2.3.1: post-greeting shifts.

6.2.2. *Greetings*

Robinson (1998) and Coupland et al. (1994) found that greetings were ubiquitous in every doctor-patient opening within their studies of primary care facilities, with the doctor initiating the vast majority of them. Greetings include variations of the word 'hello', such as 'hi' and 'hiya' and are seen as adjacency pairs (Schegloff & Sacks, 1973) i.e. the first greeting elicits a responding greeting, see section 4.3.1.1.

Despite previous research reporting that greetings were almost universal in doctor-patient interactions, there were only 54 instances of greetings within my data, six of which were patient-initiated. This finding could suggest that nurses are constructing a more task-centered approach, possibly due to time constraints leading to less time for phatic communion.

The first pair part of an adjacency pair is typically responded to with a second pair part, for example, greeting-greeting; however, the data showed that only 28 of the greetings had the preferred response to make a reciprocal greeting. This meant that 26 greetings were answered with a dispreferred response. This result was partly because of the nurses mixing the greeting with other opening sequences such as 'how are you' questions and asking for the reason of the visit (in 8 out of the 26), but a larger number of recordings (19 out of 26) showed the patient not responding to the greeting despite there being a pause, as can be seen in the three following extracts:

Extract 7: Transcript 54

> N: Hi Mrs (last name) (.) Nice to meet you (0.4) What can I do for you?
>
> P: Well I have a rash (.) but have nothing to show you (.) I do know that on my arm over the years I've occasionally had some ringworm

Extract 8: Transcript 38

> N: (first and last name) (.) I'm (first name) (.) Hiya (0.5) y'alright?
>
> P: Recently I'm not

Extract 9: Transcript 75

> N: Mr (last name) please (.) good morning (.) Hi Mr (last name)
>
> P: while I'm here
>
> N: yeah
>
> P: I could really do to see Dr X (.) I've started bleeding again (.)

In these extracts it is clear that the patient talk is more focused on the purpose of the consultation and healthcare issues than reciprocating phatic talk. This is certainly the case for patients 54 and 75 and to a degree patient 38 as she responds to a potential phatic question of 'y'alright' with a real response about her health (discussed in more detail in section 6.2.4.1). As healthcare workers are urged to be more patient-centred than task-centred, it is interesting to note that a number of patients appear to be more task-oriented by not taking up opportunities for social talk. This could certainly suggest that some patients may want to 'get down to business' and skip

social niceties, preferring a task-centred approach to a patient-centred one, at least in the initial stage of the consultation. This would fit the view of Laver (1975) that phatic communion is avoided in transactional settings and suggest that patients may see greetings as a form of lip service that is not necessarily meaningful. Overall, it appears as though both the nurses and the patients do not use greetings very often in these interactions, possibly due to the transactional nature of the consultation.

6.2.3. *Nurse Introductions*

Following the #hellomynameis campaign and the push for patient-centred communication within the NHS, it would be expected that healthcare workers introduce themselves at the beginning of a consultation. Patients report feeling a lack of trust, an inability to form a relationship and feeling like a number rather than a person (Granger, 2015; Lee, 2011; Tompkins, 2007) when a healthcare worker does not introduce themselves. These reports were made about hospital visits, but as primary care is the first call for patients, an introduction could be even more important due to repeated visits.

The number of nurse introductions within the data was surprisingly low. Nurses 5 and 6 almost always introduced themselves to new patients (with 6 out of 6 and 4 out of 5 introductions with new patients respectively), whereas nurses 2, 3, 7, 8 and 9 never introduced themselves to any of their patients. Nurses 5 and 6 were both nurse practitioners, in comparison to the other nurses, who were practice nurses. The fact that the two nurses in the more senior roles introduced themselves could be due to extra training and awareness of contemporary issues (such as #hellomynameis) or possibly because they act in a different capacity and can act as triage for the doctors. If this were the case, the nurse could introduce herself to explain her role and why the patient has come to see her, instead of a doctor. This could certainly be the case for nurse 5, who states her first name and her role in five out of the six introductions, whereas nurse 6 introduces herself using only her name. The following table shows some examples of the ways nurses introduced themselves.

Table 4: The ways in which nurses introduce themselves

N1	So my name's (first name) X2
N5	I'm (first name)
	I'm (first name). I'm the nurse practitioner X5
N6	I'm (first name)
	I'm (first and last name) X5
N10	I'm (first name). I'm one of the practice nurses X2

It is generally accepted that nurses tend to introduce themselves using their first names (Henneman & Cardin, 2014) and this certainly seems to be the case in my data. The nurses all introduced themselves using their first names. The effect of this is likely to lower the social distance and the social power between the patient and the nurse. These introductions may function to build rapport, relax the patient and possibly show them that the power between them and the nurses is equal.

6.2.3.1. *Post-greeting Shifts*

Nurses used patients' names later in the consultation in 15 interactions. However, only six of these usages were the patient's first names and were used by nurses 2, 3 and 10, as can be seen in the following table.

Table 5: The use of patient names throughout the whole interaction

Nurse	Transcript	Number of occurences in transcript	When	First name/last name	Frequency of visit	Age of Patient
2	13	3	2 x request 1 x closing	first name	frequent	older
2	16	1	request	first name	frequent	older
3	25	1	closing	first name	NSB	older
5	41	2	request and closing	last name	frequent	older
5	48	3	request, closing and small talk	last name	1 or 2	older
6	50	1	request	last name	NSB	younger
8	74	1	closing	last name	NSB	younger
8	77	1	request	last name	1 or 2	older
9	80	1	request	last name	1 or 2	older
9	82	1	closing	last name	frequent	older
9	83	1	closing	last name	1 or 2	older
9	88	1	request	last name	NSB	older
10	91	1	request	first name	NSB	older
10	95	1	request	first name	NSB	younger
10	96	1	request	first name	NSB	younger

Nurse 2 only used the first names of patients that she had seen frequently and had an established relationship with, but interestingly nurses 3 and 10 use the first names of patients they had never met before. Nurse 10 uses the patients' names when requesting information from them, for example:

Extract 10: Transcript 91

> N: So have you had some blood tests done before this one then (.) (first name of P)^

Extract 11: Transcript 96

> N: And your date of birth (.) (first name of P)^

Nurse 3 uses the patient's name during the closing:

Extract 12: Transcript 25

> N: See you (first name of P)
> P: Bye now

The use of the patients' first names could be multifunctional. On the one hand, they may show individualised care and interest in the patients, and on the other hand they may mitigate the requests via positive politeness (Brown & Levinson, 1987).

The usage of patients' last names appears to be more common, but tends to be used with older patients more frequently than with younger patients. Due to the low numbers, no clear conclusions can be made here. It appears as though in this setting, nurses tend to use the last names of patients, typically in requests and closings. These usages may be construed as deferential and avoid sounding patronising, as seems to happen elsewhere (Backhaus, 2009; Ryan et al. 1995).

Patients also used the names of the nurses in 13 of the interactions, a breakdown of which can be found below:

Table 6: Patients' use of nurse names

Nurse	Transcript	Number	When	Frequency of visit	Introduction by nurse?
1	3	1	Closing	1 or 2	No
1	6	2	discussion and closing	1 or 2	No
1	10	3	2x health discussion, closing	1 or 2	No
3	21	1	closing	1 or 2	No
5	42	2	warning and closing	NSB	Yes
5	44	1	closing	1 or 2	No
5	45	2	discussion of symptoms	NSB	Yes
6	54	1	closing	NSB	Yes
6	58	1	closing	NSB	Yes
6	59	1	closing	NSB	Yes
7	63	2	2x closing	fre	No
9	85	2	2x closing	fre	No
9	87	2	compliment and question	1 or 2	No

It would appear as though nurse introductions have an effect on patients as although there were only 18 nurse introductions in the data, five of the patients that received an introduction then used the nurse's name within the consultation. This finding is not statistically significant (fischer exact test p=0.15), although the reliability of this test is suspect given the low frequencies. I decided to qualitatively look at the usage of nurse's names by patients as the patients seemed to be showing interest and sensitivity to the nurse's introduction, as can be seen in the following extract:

> 3. N: I think I can see it ((looking at P)) (.) I'm (first name)=
>
> 4. P: =hi (first name)=
>
> 5. N: I'm the nurse practitioner
>
> 6. P: and I've got (.) two lumps there (first name) (.) they're <u>so</u> sensitive (.) do you
> see them there ((showing neck))
>
> ……
>
> 24. N: ok (3.8s) I think that's your lymph nodes ((N touching Ps neck))(1.9s) and
> it's both
>
> 25. P: it's further down a little bit (first name) ((N starts to lower hands)) (0.6s)
> there (.) there (.) there yeah yeah yeah (1.8s)
>
> 26. N: I'm just going to (.) no pain when I do that? ((N lightly presses on neck))

In this extract the patient repeatedly uses the nurse's first name after the initial introduction to discuss his health issues and to direct the nurse to the area affected. This usage of the nurse's name shows that he paid attention to the introduction, reflecting sensitivity and the usage of the nurse's name then seemed to function to lower social distance and lessen the face-threat of his directive. When asked about the nurse's introduction and his use of her first name he stated, 'She introduced herself with her first name and I like to treat people the way I want to be treated (.) so she used her first name and I used it back'. This comment reflects the patient's understanding of reciprocity and seems to suggest that he sees the reciprocal usage of first names as a sign of respect. This could suggest the importance of nurse's introductions, especially as the other patient usages, who had seen the nurses before, reflect continuity of care as the nurses must have previously introduced themselves to these patients.

6.2.4. *'How are you' Sequences*

'How are you' sequences appear in 48 of the 100 interactions. In the literature, they are typically seen as a form of 'phatic communion', talk that creates interpersonal

ties, but is semantically 'empty' (Turner, 1973, p. 212). The questions are typically formed in two ways: 'how are you' and variants of 'are you alright?'.

The view that 'how are you' (hereafter HAY) sequences are phatic can be supported by the data as 29 of the 48 questions are answered with simple, positive responses, such as: 'yeah thanks' and 'fine thanks'. As Coupland et al. (1992, p. 222) state, the hearer responds with 'thanks' in acknowledgement that the question was outside a medical frame and was part of a social ritual, which 'gives rise to bland positive appraisals plus thanking formulas that are sufficiently routinised'. However, instead of finding a majority for phatic responses, Coupland et al. (1992) found only a few HAY questions (number not given) and discovered a preponderance of nonphatic responses in their study of older patients in consultation with doctors.

Coupland et al. (1992) argue that although HAY questions can orient to phatic talk, context must be taken into account and in a medical encounter the hearer is more likely to self-disclose health-related issues than to give a purely phatic response. These questions are argued as being a transition 'into specific, medical, problem-oriented concerns' (Coupland et al., 1994, p. 105). Within the data 12 out of 48 responses included elements of self-disclosure and nonphatic orientation, which does not reflect the results of Coupland et al.'s (1992) study. This could be due to the fact that patients come to a doctor with an array of issues that are not defined before the participants of the consultation meet, whereas appointments with nurses are commonly more routine and so the patient is less likely to be unwell. Examples of self-disclosure include:

Extract 14: Transcript 2

N: How are you?

P: Well they gave me some antibiotics (.) there's four

Extract 15: Transcript 33

N: Sorry to keep you waiting (.) are you alright?

P: yeah (.) I'm alright (.) when I remember ((referring to usage of inhaler))

The following table shows the number of each type of response to HAY questions.

Table 7: Responses to HAY questions according to patient age

	Older	Younger	Total
Phatic	13 (50%)	16 (73%)	29 (60%)
Nonphatic	9 (35%)	3 (14%)	12 (25%)
No response	4 (15%)	3 (14%)	7 (15%)
Total	26	22	48

There is support from the literature that older speakers are disclosive about health issues when asked a HAY question (Coupland et al. 1988, 1991). However, my research does not show that there is a clear difference between how disclosive older patients are compared to younger patients (statistical significance testing revealed a p value of 0.33 (FET), but this test is hampered by low frequencies). When looking at raw frequencies and percentages, there do seem to be more nonphatic responses given by older patients, but this would need to be tested further.

Four out of the nine responses from older patients seemed to relate to the age of the patient, two of which are self-disclosive responses:

Extract 16: Transcript 27

> N: You alright?
> P: Difficult to orient myself.
> N: hhh yeah

In this instance, the response directly answers the question via an on-record self-appraisal. It could also be argued that the patient interpreted the question as an off-record offer of help in regard to the patient sitting down. Her response would then be a polite refusal of help by giving a reason, due to age or infirmity, for her slow speed. If a self-disclosive response, similar results were found by Coupland et al. (1994), who argue that the 'how are you' question is much more complex in a medical setting as patients must consider 'the need to present a version of "how they are" which is adequately truthful and disclosive for the moment, but also the need to

respect the current relationship and minimise threats and intrusiveness' (1994, p. 119). The most interesting responses are given by the other two older patients:

Extract 17: Transcript 24

> N: How are you?
>
> P: I'm walking
>
> N: Come on in
>
> P: I'm walking with this ((P raises walking stick))

Extract 18: Transcript 16

> N: How are you?
>
> P: Well I'm alive (hhh) at the moment
>
> N: (hh)….

In both situations the patients make jokes referring to their age (see chapter 8), these would be classed as 'facetious' appraisals 'relative to a possible expectation that the teller should not be alive' (Coupland et al., 1992, p. 224). According to Coupland and Coupland older patients tend to 'impose a more positive evaluation of a troublesome circumstance…to look on the bright side'(1998, p. 169). They claim that this is a distinctive feature of intergenerational communication. The patients are breaking typical expectations by giving more detail, but it could also be seen as politeness by remaining positive, despite difficulties in their old-age.

The remaining responses from older and younger patients tended to include attempts at humour and initial phatic responses with some self-disclosure. For example:

Extract 19: Transcript 4 (Younger patient)

> N: How are you?
>
> P: outside is alright (.) not sure about the inside
>
> N: (hh)

> N: how are you?
>
> P: I'm fine (.) umm I'm a bit (.) harassed now (.) I've come for my blood pressure check
>
> N: are you (.) yeah?
>
> P: only because I've been rushing around (.) and I've nearly ran here because I (.) you know I was on the last leg

Both of these are examples of qualified phatic responses as the respondents hedge their negative response with an initial positive or phatic response.

As seen in Table 7 there were seven instances of HAY questions that did not receive a response. Similar to greetings, HAY questions are seen as a form of adjacency pair in that a particular response is expected (Schegloff & Sacks, 1973). As we have seen previously, the expectation of a simple, phatic response is not always met in this context, but as HAY questions fit within the adjacency pair of question-answer, the preferred response of an answer would typically be expected. So why is social reciprocity not occurring in these seven instances? The following table shows four instances of no response.

Table 8: Examples of lack of a response to HAY question from nurse

Patient Number	Question	Following turn
21	N: (first and last name of P) please (.) you alright?	P: (Name of N5) just asked if you could do a renal
53	N: Some time ago (.) are you alright? (.) Have a seat (.) what can I do for you this morning?	P: Uhhh I started last Wednesday (.) with me throat
79	N: hiya (.) you alright? (0.6s) just take a seat	P: I was just at the reception (.) cause I didn't know where I was supposed to go (.) up or down

| 96 | N: you alright? (hhh) (1.7s) have you got a blood form? | P: no (.) I wasn't given one |

In all of these instances the HAY question is phrased as a form of 'Are you alright'. As Sacks (1975) argues, HAY questions can be 'greeting substitutes' (p. 66) and can replace or follow greeting turns. I believe this is even more salient when 'are you alright' is used due to its ambiguity of being both a greeting and a '*how are you*' structure. However, in all of these interactions, except 53, time is given by the nurse for the patient to respond, and if these utterances were seen as greetings, a response of a greeting would be preferred, which is evidently not given. The patients within these extracts seem to 'get straight to business' similar to the findings in section 6.2.2.

6.2.4.1. *What is the function of a HAY question?*

Heath (1981) argues that HAY questions are 'topic initiators' in doctor-patient interactions in that they establish 'what the consultation is all about' (p. 76). Further to this, Coupland et al. (1994) argue that 'HAY establishes the possibility of frame transition or a shift in activity types (Levinson, 1992), out of phatically designed, preliminary, socio-relational talk into the transaction of the medical 'business at hand' (p. 110). In this section I will look at the turns that follow HAY questions and whether these turns do shift the frame of nurse-patient interactions from socio-relational talk to medical talk. The following figure shows the number of turns that followed a HAY question until the frame changed from social to medical discourse for each patient.
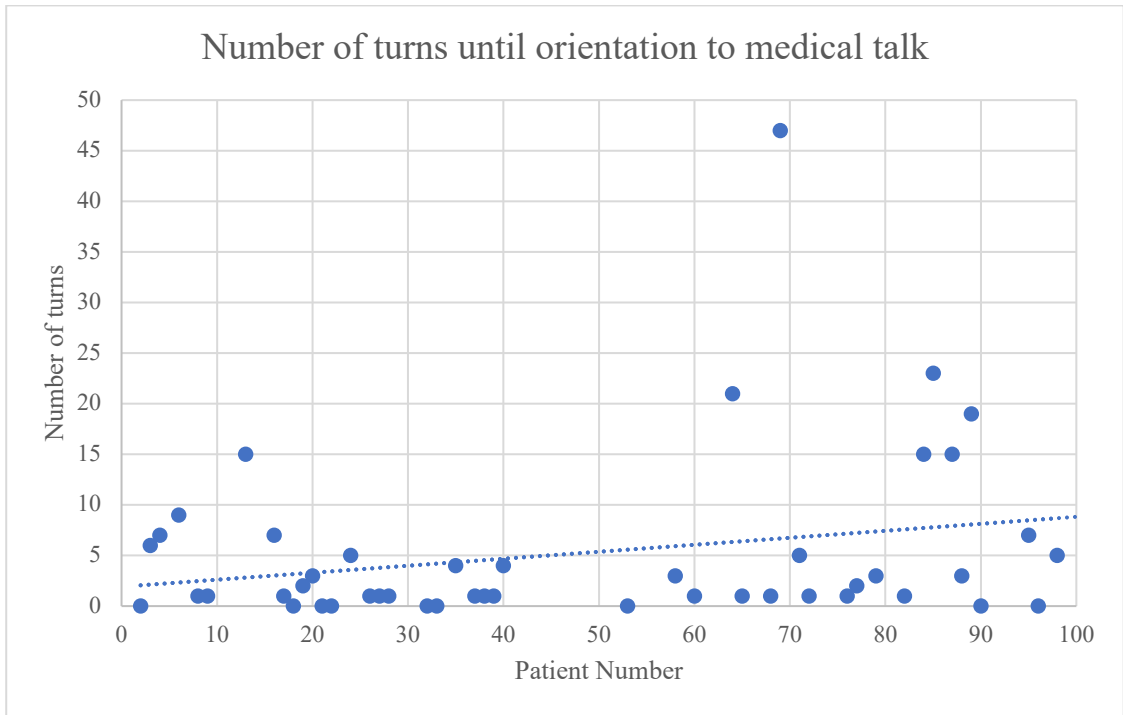
Figure 5: Number of turns following HAY sequence until frame switches to medical discourse with the mean number of turns as a base for comparison

24 interactions have no or one turn between the HAY question and discussion of medical topics or the task at hand, and 35 interactions have 0-5 turns between the two. This is consistent with the finding that HAY questions are used in healthcare consultations to switch the frame from socio-relational talk to medical talk. A couple of examples of the HAY question immediately leading to medical talk can be found below.

Extract 21: Transcript 17 (1 turn between question and medical talk)

> N: Mrs (last name) come on in (.) y'alright?
>
> P: yeah thanks
>
> N: right (.) is it cardio-vascular?

Extract 22: Transcript 32 (0 turns between question and medical talk)

> N: are you alright?
>
> P: Yeah (.) I'm here for an asthma check
>
> N: when were you diagnosed with asthma?

As discussed in previous sections, Extract 22 shows that the patient can immediately orient towards medical discourse (in this example the patient does use an acknowledgement token), whereas extract 21 displays a way in which the nurse, after the HAY sequence can immediately swap from relational talk to the task at hand. The nursing data revealed different types to doctor-patient HAY responses. Coupland et al. (1994) found that in doctor-patient interactions the third move (response after answer to HAY) would typically involve:

1. Endorsements (e.g. 'good')
2. Providing a non-specific probe (e.g. 'not well?')
3. Asking a further HAY
4. Setting an agenda for the patient (e.g. 'you were short of breath last time I believe?')

<div align="right">(examples from Coupland et al.'s 1994 data)</div>

However, nurse interactions would most typically begin with a discourse marker, such as 'right' and one of the following:

1. A question about the reason for the visit (as seen above)

2. A follow up question (e.g. P8 N: (hhh) right (.) are you still taking all your medication?)

3. Asking the patient to prepare for the procedure (e.g. P17 N: which arm is best?; P27 N: right (.) do you have your blood form?).

These differences in the following turns are most likely due to the differing roles of the nurse and the doctor. Patients usually come to see a nurse in a GP practice for reasons that have already been logged in the system, for example, they've been called in for a blood test or a B12 injection. However, patients would see a doctor for a multitude of reasons that are not typically specified before the interaction takes place. This enables the nurse, and the patient, to move directly into medical discourse without the need for probing (as would occur in Coupland et al.'s third moves 2 and 3).

As can be seen in figure 5, interactions 13, 64, 69, 84, 85, 87 and 89 involve a large number of turns after the HAY question before medical discourse is introduced. These interactions typically involved small talk relating to the patient's life with the nurse asking a number of questions. These interactions show a larger interest of the nurse in the patient's life and general well-being rather than focusing purely on health.

Extract 23: Transcript 69

2.P: hiya [y'alright?]

3.N: [y'alright?]

4.P: yeah (.) not bad th=

5.N: =yeah (.) good good (hhhh) ((laughing because talking over each other)) we have a friend ((referring to researcher))

6.P: spectator (.) oh she's wonderful (.) I can tell you that now ((speaking to researcher))

7.N: (hh) that's only because I'm doing this blood test (hhh)

8.P: no no no no (.) but you are (hhhh) I come a lot to her (.) with my mum

9.N: yeah (.) how is she?

10.P: she's ok

11.N: is she?

12.P: yeah (.) um (.) they've been having the district nurse going out

13.N: oh right

14.P: because she did come and she saw (.) is it (.) (name of N6)?

15.N: yeah

16.P: and (N6) lives a couple of doors up from my mum

17.N: ahh

18.P: she just said 'oh (.) I'll get the district nurse to come and do it'

19.N: oh great

20.P: so

21.N: oh well that's [handy]

22.P: [because it] hadn't (.) it hadn't (.) oh she knocked the scab

23.N: ow:

24.P: off it (.) ah: (.) so (.) but (.) it's ok

25.N: yeah

26.P: but [her legs aren't great]

27.N: [so are they coming once a week] (.) or?

28.P: uhh (.) they have been doing

29.N: yeah (.) yeah

30.P: I think in fact (.) I think she was going today

31.N: oh right (.) right (.) [oh that's good]

32.P: [that's reminded] me (.) yeah

33.N: yeah

34.P: so no (.) she's umm (1.2s)

35.N: well that's good

36.P: it just saves (.) well (.) it just [helps us out as well]

37.N: [and you as well] doesn't it? (hh) (.) aww I miss her (.) but uhh

38.P: yeah

39.N: I understand [from your point of view]

40.P: [she's she's got uhh] yeah well (.) she's got a hospital appointment tomorrow (.) so (.) obviously I'll have to take her for that

41.N: yeah

42.P: and she's I took her last week for her hearing-aid

43.N: oh (hhh)

44.P: to get that sorted (.) it's like

45.N: I know (.) it's always something (.) isn't it?

46.P: and you kind of save on one thing=

47.N: yeah=

48.P: then [you know (.) it helps]

49.N: [yeah (.) yeah yeah] (.) now how are you doing?

50.P: yeah (.) I'm alright

51.N: so what's happening?

52.P: well (.) obviously I went to see Dr X (.) uhh Dr X after my last one (.) she said they hadn't changed (.) my white blood cell count

In this interaction the nurse and the patient are still discussing health related issues, but are talking about the health of the patient's mother – something that is not directly relevant to the patient's health. The patient introduces the topic of her mother in turn 8 and the nurse responds by asking about her. She apparently shows genuine interest by reiterating the 'how is she' question in turn 11. The patient provides more detail throughout the following turns and the nurse shows further interest by back-channeling (e.g. turns 13, 15, 17) and asking further questions (e.g. turn 27). In this interaction, the nurse uses Coupland et al.'s (1994) third move of asking a further HAY question in turn 49 and once again in turn 51 to direct the conversation back to the patient's health, but evidently the opening sequence of this interaction was lengthened by small talk that followed the initial HAY questions in turns 2 and 3. It is obvious that the nurse and the patient already had good rapport with one another and this seemed to be the case with the vast majority of interactions in which medical discourse did not swiftly follow the HAY sequence. The following table displays the number of turns following a HAY question according to the frequency of visits the patient had with the nurse.

Table 9: Number of turns following HAY sequence before switch to medical discourse according to patient frequency of visits

	Never seen before	Seen once or twice	Frequent	Total
0-2 turns	9	11	6	26 (55%)
3-5 turns	7	2	0	9 (19%)
5-10 turns	1	3	1	5 (11%)
10+ turns	1	2	4	7 (15%)
Total	18 (38%)	18 (38%)	11 (23%)	47

This table captures some descriptive trends in the data, but the frequencies are too low to test significance. Clearly moving straight into medical discourse is the most typical phenomenon. However, there does seem to be an emerging trend that the more frequent the patient, the more small talk seems to occur (in my data). Despite the lower number of frequent patients, there were more instances of 10 or more turns following the HAY question with frequent patients. It appears as though when a relationship is formed the nurse and patient are more likely to discuss phatic topics than to move straight to medical discourse and the task at hand, which is unsurprising as rapport has been built and interest in the other person would typically increase.

6.3. Openings: Summary

Overall, the analysis of openings within my data has uncovered a number of features. The structure of nurse-patient openings in GP surgeries seems to differ from that of doctor-patient interactions. Coupland et al. (1994) found that doctor consultations would typically open with a summons/approach. This was similar within my data, but the summons seemed to have a dual purpose in that it also acted as a familiarity sequence, allowing the nurse to check the patient's identity. The familiarity sequence of the opening was generally omitted as the nurses did not tend to introduce themselves, with only 18 nurse introductions taking place within my data. The majority of these were done by nurses 5 and 6.

The greetings phase of openings in nurse-patient interactions was not nearly as common as in doctor-patient interactions, with only 54 instances occurring throughout my data compared to the almost universal use by doctors (Coupland et al., 1994). A similar situation arose with 'how are you questions' as just under half of the interactions involved a HAY sequence. This could suggest the nurses are constructing a more task-centred approach, possibly due to time constraints leading to a shorter consultation. Additionally, these sequences may not be as necessary as in doctor-patient consultations. Patients typically come to a doctor with an array of potential issues, of which the doctor may not be aware (necessitating the need for a HAY sequence with a non-phatic response), whereas a nurse consultation is typically more routine (such as blood tests, asthma and diabetic reviews etc.) and may not require as much probing into the patient's existential state. This suggestion was furthered by the lack of reciprocity to HAY questions and greetings. 26 of the 54 greetings were met with a dispreferred response, 7 of the HAY questions went unanswered and 29 responses were merely phatic. The lack of reciprocity from patients could suggest that they themselves are creating a more task-centred approach, than typically assumed in the research, where the efficiency of the consultation is assumed to be driven by the nurse alone.

In regard to differences between younger and older patients, both ages showed a preference for the use of their first names, despite Wood and Kroger (1993) suggesting that this may be a sign of disrespect, especially for older patients. Although these findings suggest that first name usage may be preferred by the majority of patients, I would not suggest using first name terms without a check with the patient first to ensure their comfort, but usage of first names (with permission) could help lessen the social distance between the two participants. Such a check was done by nurse 10 in transcript 91:

Extract 24: Transcript 91

N: [Is it] alright if I call you (first name)?
P: Yes (hhh)

A difference was found in the use of non-phatic responses to HAY questions. Coupland et al. (1988; 1991) hypothesised that older speakers would be more disclosive about health issues than younger speakers. My data supports this as 9 out of 26 responses from older patients were non-phatic in comparison to 3 out of 22 responses from younger patients. The older patients' responses also seemed to relate to the age of the patient via self-disclosive responses and facetious appraisals (Coupland et al., 1992).

Finally, individual interpersonal practices by the nurses were evident in the use of nurse introductions. Nurses 5 and 6 both almost always introduced themselves to new patients and interestingly the patients would then use the names of the nurses, typically in the closing of the interaction or in the transactional phase. This shows a sensitivity in the patients as they remembered the nurses' names and used them, possibly to show respect or potentially to build rapport. This linguistic strategy also seems to be appreciated by patients, when used by nurses, according to the interviews:

Extract 25: Transcript 42 (Older female patient)

R: Do you like them to use your first name?
P: Yeah (.) it makes you feel old if they use your last name

6.4. Closings

Similar to openings, very little research has been done into the closing phases of a nurse-patient interaction, despite claims that a positive closing can influence patient satisfaction, mitigate any feeling of rejection and purportedly improve post-consultation care (Coupland et al., 1992; Hall & Dornan, 1988; White et al., 1997).

6.4.1. *Who Starts the Closing of the Interaction?*

As noted by White et al. (1997), the majority of closings were led by the healthcare worker, in their case a doctor. They found that only 9% of closings within their data were led by the patients (in a study of 22 interactions). Within my dataset, only 6% of closings were led by the patients, suggesting that nurse closings of consultations are similar to doctor closings in that the healthcare worker almost always initiates the closing frame.

When younger and older patients initiated closings, they tended to ask direct questions, for example 'is that me?' (30) and 'I'm done?' (36). They also used arrangement related pre-closings such as 'ok (.) I'll see you in six months' time' (4). That patients led closings at all is of interest as typically the nurse closes the interaction (in this dataset and previous research), but here the patients' conversational turns seem to display a desire to leave. This might suggest that the consultation is infringing upon their time and thereby threatening their negative face. By doing so the patient might also threaten the nurse's positive and negative face, as the nurse might have unspoken information to relay or further questions to ask.

6.4.2. *Structure of Closings*

The only research that has looked into nurse-patient closing structures just gives a brief account of the elements contained in a closing phase, which are as follows:

- Summary of arrangements
- Asking for further questions or concerns
- Reminder of how to contact nurse
- Expressions of future contact
- Terminal exchange

> (Staples (2015), discussed in more detail in section 4.3.2.)

Apart from this, the literature on doctor-patient interaction is thin, with the exceptions of Robinson (2001), who argued that a doctor-patient consultation will

typically be pre-closed by arrangement related discourse or final concern initiators, and White et al. (1997), who found a physician summary of the issues with reminders of follow-up treatment (see section 4.3.2). The current dataset displayed somewhat similar elements in a GP nurse-patient interaction, but there were also some distinct differences.

The typical structure of a closing for both nurses and patients was as follows. The closing would be initiated with a discourse marker with rising intonation (as noted by Robinson (2001) and Schegloff & Sacks (1973), which would then be immediately followed by topical organization, such as a summary of arrangements or confirmation of future contact. These were phrased as statements that the patient (or sometimes nurse) would respond to in three ways:

1. Raise further concerns or 'unmentioned mentionables' (Schegloff & Sacks, 1973)

   Transcript 23: N: Right^ =(.) so that's us

   P: =Yeah good good good (.) if there's anything they =will be in touch (.) won't they^ (.) no problem

2. Discuss things that aren't related to medical issues e.g. small talk

   Transcript 67: N: we'll squeeze you in there (7.7s) that'll be fine (5.9s) there we are (.) all in (.) yep (.) there we go

   P: can you use one of those? ((referring to computer))

3. Acknowledgement of closing via the usage of a discourse marker such as 'ok' or 'right'.

   Transcript 1:   N: so^ (.) we'll try diet

   P: right

If the pre-closing was acknowledged, the interaction would lead to closings which typically involved thanks and parting sequences. However, if the pre-closing led to small talk or further concerns, another pre-closing would be initiated once that topic was discussed.

The typical structure of a closing for both nurses and patients was, therefore, as follows:

```
Discourse          Topical              Further
marker (pre-       organization        Concerns
closing)           e.g.
                   summary of          Small talk
                   issues
                                       Acknowled-    Thanks     Parting
                                       gement of
                                       closing
```
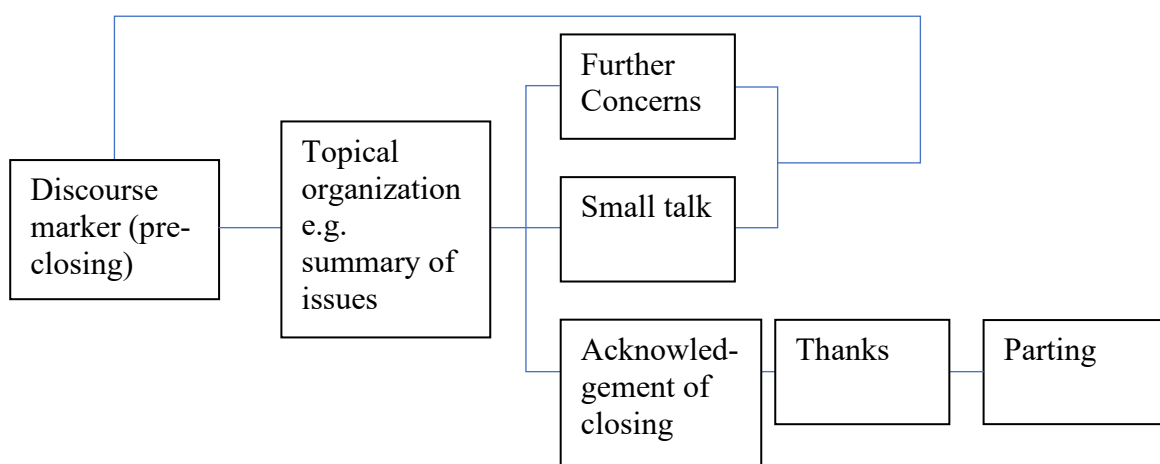
Figure 6: Typical structure of a closing

The following table shows the number of pre-closings used in each interaction within the dataset.

Table 10: The number of pre-closings used in each interaction

Number of pre-closings	The number of closings in the data set containing a one or more pre-closings
1	49 (49%)
2	39 (39%)
3	10 (10%
4	2 (2%)
Total	100

Evidently, numerous pre-closings were used in 51 of the interactions, whereas only one pre-closing was needed in 49. Only two of the recordings used more than three closings, showing that the hearer was typically perceptive of the moves made to close the consultation.

A second format to the one I have just outlined, occurred in 38 of the interactions, most typically in those that only included one pre-closing. In those cases, the nurse, or sometimes the patient, used a discourse marker of 'ok' or 'right' with a rising intonation to refer to the first pre-closing and closed the interaction without the need for another pre-closing turn. This can be seen in transcript 55.

1.N: whatever it was (.) it's cleared up so that's good^ (.) alright (.) can I help with anything else?

2.P: ummm yep (.) I just wanted to ask a question on (.) I think Dr (last name) is going to be calling me next week so

3.N: ok

4.P: so that's about (incomprehensible)

5.N: right ok

6.P: but [(incomprehensible)]

7.N: [that's sorted] (.) are you sure?

8.P: yeah

9.N: alright

10.P: I just thought while I'm here (.) you know (.) I'll ask but it's not a problem

11.N: ok^

12.P: ok then (.) thanks very much for seeing me

13.N: aww (.) I'm glad you're feeling better

14.P: yeah

15.N: nice to see you (.) alright (.) bye bye

In turn 1 the nurse initiates a closing by using a discourse marker of 'alright' and following this with topical organization by asking if there are any further issues. The patient raises an issue and this is discussed until turn 11 when the nurse uses another pre-closing discourse marker. The patient acknowledges the move and in the same turn moves to thanks and appreciation for the nurse's time.

Using the findings of Staples (2015) combined with two novel forms that were discovered in my data (indirect statement and research related), five types of closing topic initiators were identified. These were future contact, final concern, summary of issues, research related and indirect statements. The following table shows the breakdown of initial closing topic initiators:

Table 11: Forms of initial closing topic initiators used by both nurses and patients

	Future Contact	Final Concern	Summary	Research Related	Indirect Statement	Total
Nurse	30 (32%)	9 (10%)	21 (22%)	2 (2%)	32 (34%)	94
Patient	2 (33%)	1 (17%)	0	0	3 (50%)	6

The most common first pre-closing that was used by nurses was not covered by any of the aforementioned literature. 32 instances from nurses used an indirect statement of finality to convey that both the procedure was complete, and that the consultation was coming to an end. These were labelled as indirect statements as the nurse was commonly referring to the procedure being finished, but within this statement also signalling that the consultation as a whole was at an end. Examples of such are: 'there you go' (transcripts 8, 11, 13); 'we're done' (16) and 'that's us' (23, 28). Whilst these turns out of context could be seen as somewhat direct and abrupt, the nurses most typically used these statements following a blood test. These may imply a polite belief that the patient will be relieved to hear that the procedure is done (as a needle could threaten their negative face wants and make them feel uncomfortable). The following excerpts show two examples of indirect statements being used in context:

Extract 27: Transcript 11

1.P: Brilliant (.) Not caused me any problems it's just adding onto the uhh MRI scan that I had
2.N: Oh right ok
3.P: On top of everything else hhhhhhhh
4.N: ((N puts plaster on P's arm)) there we go (.) all done (.) lovely
5.P: Perfect (.) thank you very much
6.N: Thank you (.) have a good day (.) bye
7.P: See you again

Extract 28: Transcript 23

1.N: ((N types on computer)) Right^ [(.) so that's us]

> 2.P: [Yeah (.) good] good good (.) if there's
> anything they [will be in touch (.) won't they? (.) No problem] ((stands up))
> 3.N: [Yeah (.) yeah (.) yeah (.) alright^]
> 4.P: Ok my dear thank you very much
> 5.N: no problem

As can be seen in the two transcripts the nurses are finishing up the procedures in the first few turns and indicate that they have finished in turns 4 and 1 respectively. The patient in extract 27 responds immediately with an acknowledgement of 'perfect' and moves on to thanking the nurse, whereas in extract 28 the patient has a question about her results, but still acknowledges the pre-closing by standing up and in turn 8 thanking the nurse.

'Arrangement related' closings were the second most common with 30 interactions, especially future arrangement related pre-closing from the nurses. For example,

- transcript 67 'N: we'll squeeze you in there (7.7s) that'll be fine (5.9s) there we are (.) all in (.) yep (.) there we go'
- transcript 14 'N: Right (.) You're due roughly (.) roughly (.) so you know to book in about a month before don't you (.) b12 on the 27th of August (.) is that ok? (.) cause you're every 12 weeks aren't you

The next most frequent pre-closing by nurses was a summary of the issues and follow-up treatment with 21 closings initiated in this way. For example,

- transcript 3 N: alright then (.) so give that a try
- transcript 45 N: so (.) that's the antihistamine (.) once a day

Interestingly, there were only 9 instances in which the nurses used a final concern initiator such as, 'can I help you with anything else?' and these were typically phrased very minimally as 'ok?' (transcripts 25, 35 and 39). This lack of final concern initiators could be due to the nature of a nurse's consultation as patients will come to them for one pre-specified purpose as opposed to a more fluid doctor consultation (see Robinson 2001).

Finally, there were two instances of research-related topic initiators. Here the nurse would use the research that was taking place to inform the patient that the consultation was coming to an end. As these were indirect hints they were seen as being similar to the indirect statements mentioned above. An example of this is found in transcript 85:

Extract 29: Transcript 85

> N: right (.) are you alright for Michaela to have a quick word with you about=
> P: =yeah (.) fine (.) yeah (.) fire away (.) yeah

Looking at the use of initial pre-closings and topic initiators allows us to gain an insight into the most common ways in which a nurse starts the closing frame of an interaction. However, 51 of the recordings showed a number of pre-closings taking place, and these should be discussed in further detail. The following table shows the most frequent forms of pre-closings, comparing initial pre-closings with ones uttered afterwards.

Table 12: Number of initial pre-closings compared to following pre-closings for patients and nurses

	Future Contact		Final Concern		Summary		Research Related		Indirect Statement		Total
	Initial	Post	Initial	Post	Initial	Post	Initial	Post	Initial	Post	
Nurse	30	22	9	18	21	3	2	2	32	7	146 (87%)
Patient	2	2	1	3	0	3	0	1	3	7	22 (13%)
Total	32 (19%)	24 (14%)	10 (6%)	21 (12.5%)	21 (12.5%)	6 (4%)	2 (1%)	3 (2%)	35 (21%)	14 (8%)	168

Future contact, summaries of issues and indirect statements are the most used first pre-closing topics. Future contact has somewhat similar results for both initial and post topic initiators, whereas final concern initiators are most commonly used after the initial pre-closing. It is also interesting to note that the patients used more post-initial pre-closings: only 6 interactions showed the patients leading a closing whereas there are 16 instances of patients using a pre-closing after the initial one. One possible explanation for this is that the patient understood the nurse's attempt to introduce a closing frame and, after discussing further issues (or small talk), reintroduced the closing frame in a form of negative politeness by showing they understood the nurse's wants. This can be seen in transcript 67:

Extract 30: Transcript 67

1.N: we'll squeeze you in there (7.7s) that'll be fine (5.9s) there we are (.) all in (.) yep (.) there we go
2.P: can you use one of those?
3.N: (hh) it's a case of having to isn't it?
4.P: well it's your job (.) you've got used to it haven't you?
5.N: yeah I have (.) I don't like it (.) no
6.P: you [don't like it? no]
7.N: [I don't] really like this programme
8.P: (to researcher) put that off quick (hh)
9.N: (hhhh) I'll get into trouble (.) but the other one was much easier and more friendlier and (.) you know things like that (.) well (.) I find this one a little bit
10.P: it's warm too (referring to print out)
11.N: yeah (.) hot off the press (hh)
12.P: yeah (.) so that's it
13.N: yeah
14.P: thank you very much [for doing it]
15.N: [you're welcome] you're welcome

Here the nurse uses a pre-closing in turn 1 by giving the patient another appointment and using a finality statement, 'there we go'. The patient in turn 2 starts some small

talk about computers, but then in turn 12 uses an indirect statement of 'so that's it' to return to the closing of the interaction, which the nurse acknowledges with a 'yeah'.

In order to understand why some closings are used more initially and others used later, I decided to look at types of consultation, as it was expected that direct closings (and only one pre-closing) would be used most typically with transactional appointments such as giving blood and vaccinations, and final concern initiators along with a number of pre-closings would occur in health review consultations. The following table shows the average number of pre-closings for each type of consultation with the number of patients and the range in brackets.

Table 13: Average number of pre-closings compared to purpose of consultation with range in parenthesis

Type of visit	Purpose of Visit	Number of Patients	Number of Pre-closings	Indirect statements	Future Contact	Final Concern	Research Related	Summary
Transactional	Bloods	40	1.575 (1-3)	0.78	0.5	0.13	0.1	0.1
	ECG	1	1 (1)	1	0	0	0	0
	Cold	3	1.33 (1-2)	0	0.33	0.33	0	0.67
	Vaccination	4	1.5 (1-3)	0.5	0.5	0.25	0	0.25
	B-12	9	1.44 (1-3)	0.4	0.27	0.54	0	0.36
	Blood Pressure	2	1.5 (1-2)	0	0.5	0.5	0.5	0
	Contraception	2	1 (1)	1	0	0	0	1
	Wound dressing	4	2 (1-3)	0.5	1.25	0	0	0.25
	Aches and pains	11	1.63 (1-3)	0	0.64	0.54	0	0.45
Total Average			**1.57 (1-3)**	**0.53**	**0.44**	**0.19**	**0.06**	**0.34**
Health review	Diabetic Review	13	2.15 (1-4)	0.31	0.77	0.54	0	0.54
	Asthma Review or test	11	1.73 (1-3)	0.54	0.27	0.54	0	0.36
Total Average		**100**	**1.96 (1-4)**	**0.41**	**0.52**	**0.54**	**0**	**0.45**

Transactional appointments had a lower average number of pre-closings (1.57) than health review consultations (1.96). A statistically significant difference (FET p=0.03) was found in in the number of final concern initiators used in transactional and health review consultations. This could be due to more potential concerns being raised by patients in a health review consultation and nurses knowledgably tackling this issue. Finally, the average number of indirect statements used for bloods in comparison with other consultation types was higher at 0.78, which might imply a polite belief that the patient will be relieved to hear that the procedure is done (as a needle would most likely threaten their negative face wants).

6.4.3. *Partings and Thanking*

6.4.3.1. *Thanking*

Following pre-closings and topic initiators the consultation would typically end with thanks and a parting. It was expected that thanks would occur in medical transactions as it typically does in service transactions (Aijmer, 2014; Rubin, 1983). Also, it can function as a signal to show that the interactants aim to end the interaction. Aijmer's (2014) study noted that thanking often appeared in succession in telephone calls before exchanging farewells, and more frequently in business related telephone calls. A similar finding was discovered in this medical dataset as thanks appeared in 80 out of the 100 interactions. Of these 80 thanking turns 41 involved the patient thanking the nurse repeatedly between 2 and 4 times. This can be seen in transcript 63 where the patient thanks the nurse three times:

Extract 31: Transcript 63

P: alright (.) thanks for fitting me in (first name)
N: ok (.) alright
P: cheers
N: you're welcome
P: thanks (first name)
N: bye

The repetition of thanks in just over half of the interactions that include thanking turns could reflect sincerity; Aijmer notes that 'one of the most important strategies reinforcing politeness consists of the use of combinations and repetition' (2014, p. 35). Another hypothesis is that the weight of the imposition (Brown & Levinson, 1987), i.e. the consultation type and taking up the nurse's time, could be a factor in the amount of thanks used. This could be especially true if the consultation ran longer than expected. The length of consultation was tested in terms of the amount of thanks used, but no statistically significant results were found. To see the descriptive data of this testing, please see appendix 4.

As noted above, 80 of the interactions included thanks, but this also meant that 20 interactions lacked any thanking turns. A lack of thanks most typically occurred in interactions that involved injections; 14 out of 53 of these interactions involved no thanks at the closing of the interaction, examples of which can be found below.

Extract 32: Transcript 69

N: so those should all be back for Thursday

P: brilliant

N: and then (.) if there is anything wrong there then at least we can get something started

P: you know what you're working with then

N: yeah (.) [yes you do]

P: [yeah (.) defin]itely (.) ok

N: alright then

P: see you again ((P gets up and walks towards the door))

N: alright (.) ok

P: bye (.) bye ((P exits))

Extract 33: Transcript 14

P: So that's when I'm due

N: Yeah

P: Cause I've got an appointment with the GP around about then so

> N: Yeah so umm cause I'm not on the system I can't book it yet 'cause we don't know where we are umm if holidays and stuff (.) so b12 due roughly around there
> P: Okey doke ((P gets up and walks towards the door))
> N: Okey dokey ((P exits))

In transcripts 69 and 14 the nurses ends the consultations discussing the patient's next visit. In transcript 69 the nurse uses a discourse marker 'alright then' to refer to her previous pre-closing and the patient acknowledges this by using a parting, 'see you again'. In contrast, in transcript 14 the patient responds with 'okey doke' and the nurse reciprocates this language. Neither interlocutor says thank you or uses a parting turn. This is not to say that patient 14 was dissatisfied as he commented in the interview that the visit went 'very well' and that he likes Nurse 2 in particular as she 'puts you at ease (.) and she's talkative and not judgemental'.

One possible reason for a lack of thanks in these interactions could be due to the nature of the consultation as an injection would most typically threaten the patient's negative face and could lead to a lack of thanks as they do not see the consultation as having benefitted themselves, but rather the opposite. Norrick claims that 'the social function of thanking is generally the acknowledgement of one's having benefitted from the actions of another person' (Norrick, 1978, p. 285) so if the patient feels they haven't benefitted, this may result in a lack of thanks. However, this was not reflected in the interviews and so at this stage is pure speculation.

Finally, patients most typically introduced thanks (in 72 interactions). However, in eight of the interactions that included thanks the nurse started the thanking turns. Interestingly, this was most typically done by nurse 4, who led the asthma clinic. She introduced thanks in six of her interactions. The data does not account for why this might be the case. However, it could be speculated that she introduced thanks because she had a large number of 'did not attend' patients throughout the time that I sat with her and this may have led her to thank the patients that did attend their sessions.

6.4.3.2. *Partings*

Following thanks, farewells or partings would typically take place (Aijmer, 2014; Staples, 2015). 53 interactions involved a typical adjacency pair (or sometimes triplet) such as, 'bye – bye'. However, 23 involved half of an adjacency pair with one speaker uttering a parting without a response and 24 involved no partings whatsoever. It was expected that partings would be present in almost all interactions as, similar to telephone conversations, medical appointments are an 'occasion [that] is more or less coterminous with the conversation' (Schegloff & Sacks, 1973, p. 325). Despite this, partings were not as prevalent as expected. The most obvious reason for this is that thanks from the patient could be acting as a parting, as observed by Aijmer (2014).

Table 14: Patient use of thanks with use of parting

	No partings	1 parting	Total
Thanks	15	22	37 (79%)
No thanks	9	1	10 (21%)
Total	24 (51%)	23 (49%)	47

Table 14 shows that of the 24 interactions without any partings, 15 included thanks, and of the 23 interactions with only one parting utterance, 22 included thanks. This finding is statistically significant with a p value of 0.00 (FET). This would suggest that in these closing turns the thanking turn is being used as a parting gesture and would explain why there is such a high number of interactions without a typical parting adjacency pair. This can be seen in transcripts 2 and 42, but occurs frequently throughout the data. For example:

Extract 34: Transcript 2

P: yep (.) OK thank you very much
N: alright then (.) bye
P: thank you ((P leaves room))

Extract 35: Transcript 42

P: Yeah (.) ok (.) thank you very much (first name of N)

> N: Ok (.) bye:: ((Patient exits))

However, there were still 10 interactions that did not contain either thanking turns or parting turns, which is interesting given the service nature of the consultations. Two examples of these can be found below:

Extract 36: Transcript 33

> N: umm (.) ok (.) is that alright?
>
> P: yeah
>
> N: I'll just umm (2.5s) have I missed anything? I can't think (.) that was short and sweet wasn't it^
>
> P: it was
>
> N: I think (hh) so that was it wasn't it (.) yeah
>
> P: all done?
>
> N: go outside and come back in now (hh)

Extract 37: Transcript 19

> N: Right love (.) you're all done
>
> P: Sorted ((P leaves room))

Both of these examples end with an indirect statement of finality, which could lead to a lack of a typical parting as it is acting as one. This lack of typical partings is interesting as one would expect a parting to occur within this setting, the lack of which could result in a positive face threat. Due to there only being a small number of these closings this would have to be researched further.

On the other end of the scale there were 41 partings that included positive politeness, such as compliments and well-wishes from the nurse ('take care', 'nice to meet you'). A number of these related to the small talk that took place within the consultation, for example in transcript 21 the nurse utters the directive 'enjoy your trip' and furthers this by making a joke 'take me with you next time' (see chapter 8). Further to this, in transcript 29 the same nurse wishes the patient 'good luck with your shop'. These utterances display interest in the patient and show that the nurse

was paying attention to the small talk they had during the interaction. While they function to build rapport and act as a 'conversational loop' (Aijmer, 2014, p. 61).

6.4.4. *Closings Summary*

Overall, this section has taken a closer look at the structure of closings in nurse-patient interactions. No differences between older and younger patient consultations were found in the closings of my data and so this research question was not pursued.

Nurses almost always led the closings in the dataset with only 6% of closings being led by the patients. Closings were typically initiated by the use of a discourse marker with rising intonation, similar to the findings of Robinson (2001) and Schegloff & Sacks (1973). This was then followed by topical organisation, in which the nurse might discuss future contact or summarise the arrangements of care. Three potential responses to the introduction of a closing were found to be used by patients; raising further concerns, making small talk or acknowledging the closing. If one of the two former options was taken, the closing process would typically repeat itself until the closing was acknowledged. Closing topical organisation varied between organising future contact, asking about final concerns and summarising the arrangements of care (similar to the findings of Staples (2015). However, two new forms of topical organisation were found. The first was used due to the methodology of my data collection ('reseach related'). The other, which was labelled as an indirect statement of finality, conveyed that the procedure had been completed whilst also hinting that the consultation was coming to an end via utterances like 'there you go' and 'we're done'. These were most commonly used in transactional consultations. Following from the pre-closings, thanks would typically occur and were found to be repeated frequently, possibly to show sincerity (similar to the findings of Aijmer (2014)). A typical parting adjacency pair only occurred in half of the interactions, as thanks may have assumed the role of partings in a number of consultations.

There was an interesting lack of final concern initiators used by the nurses, a feature of closings that could be seen as being patient-centred to allow the patients to raise any further issues and potentially display satisfaction with decisions made

throughout the consultation. However, this could be due to the nature of the nurse-patient consultation in that patients will typically come to a nurse for a specific reason that is outlined before the interaction takes place. Overall, the structure of the closings of consultations was quite complex and often took place over a large number of turns.

6.5. **Conclusion**

In conclusion, the openings and closings of nurse-patient interaction within a GP surgery revealed several differences with doctor-patient interactions. A number of features such as greetings and healthcare worker introductions or a 'familiarity sequence' (Coupland et al. 1994) were not as dominant in nurse-patient consultations. This was reinforced by finding that almost half of greetings uttered did not receive the preferred response of a reciprocal greeting. A number of 'how are you' structures also lacked expected social reciprocity which was accounted for by the patients' potential wish to 'get down to business' and constructing more of a task-centred approach in the consultation. 'How are you' third move responses were also different to those of doctor-patient interactions (Coupland et al., 1994) as the nurses within my dataset tended to (a) ask about the reason for the visit, (b) ask a follow-up question and (c) ask the patient to prepare for the procedure. This differed from the potentially more patient-centred approach of doctors who would respond with endorsements (e.g. 'good') and non-specific probes (e.g. 'not well?') (ibid.). It is likely that the differing roles of the nurse and the doctor account for these differences as patients typically see a doctor for a multitude of reasons that are not always specified before the consultation takes place.

Similar to doctor interactions, nurses tend to initiate conversational closings (White et al., 1997). A typical structure for nurse-patient closings was drawn up based on the data and an interesting lack of final concern initiators was found. This could once again be due to the nature of a nurse's consultation, but could also lead to the perception of a more task-centred approach, although this was not highlighted in the interviews.

Overall nurse-patient openings and closings appear to be more task-centred than doctor-patient interactions, but this is not to say that the patients feel dehumanised. Several patients would lead the conversation to its medical purpose and skip phatic communion in favour of a serious frame. This could highlight a difference in how patient's perceive nurse consultations versus doctor consultations.

CHAPTER 7

7. REQUESTS

7.1. Introduction

Researchers have noted that nurses and caregivers use an increased number of imperatives when talking to older patients (Grainger, 1993; Herman & Williams, 2009a) and a number of proposed features of 'patronising talk' occur within and around directives, for example, terms of endearment, minimisers, simplified lexis and use of first names (for a more extensive list see section 3.5.1.2). However, politeness is also typically involved in requests as the speaker is attempting to get the hearer to do something for them (Searle, 1969), which can lead to negative face threat or threatened equity rights (Spencer-Oatey, 2008). The nature of a nurse-patient consultation 'involve[s] a need to probe into private areas, deal with embarrassment, and make requests that impinge upon clients' autonomy or privacy' (Spiers, 1998, p. 28). An example of such would be requests that surround the giving of injections, a frequent feature in the recorded interactions, which could easily threaten the patients' equity rights in terms of autonomy as they may feel the injection is being imposed upon them and the need for the needle is outweighing their specific wants or desires. This could be disputed, however, as the patients all came to the appointment knowing its purpose and outcomes. Many people dislike needles and it is interesting to note that almost all patients in the study looked away whilst the needle was in their arm, suggesting that it did indeed make them feel uncomfortable.

Upon analysing requests I will at first discuss the structural patterns of the requests with a slightly modified version of Aijmer's (2014) typology of request patterns. The traditional approach of Blum-Kulka et al. (1989) has been disregarded due to a number of issues when attempting to apply it to my data. The shortcomings of this framework have been discussed in the literature review (section 4.4.1), but a summary can be found below:

- The framework was built upon participants claiming what they would say in a discourse completion test. What people actually say and what they think they say can be very different. (Holmes, 1991; Wolfson et al., 1989).
- Blum-Kulka's taxonomy ignores 'let's requests', as noted by Culpeper and Archer (2008), which are plentiful throughout my data.
- The categories of requests noted by Blum-Kulka et al. were found to be too broad and the distinction between structures blurry. Similar to Culpeper and Archer (2008), viewing pragmalinguistic strategies in detail led to a more in-depth analysis of the data.

The analysis of my data took a bottom-up approach, similar to the study of Mulholland (1994), considering the ways in which requests were made and when and how they were responded to. This led to the discovery of three main forms of requests that are specific to this institutional setting:

- Opening sequence requests – requests that occurred during the opening stages of the interaction and consisted mainly of requests to sit down or enter the room
- Procedural requests – these were connected to the various procedures that occurred during the 'exam' phase of the interaction (Staples, 2015), such as taking blood, weighing the patient, taking blood pressure etc.
- Follow up requests – these consisted of directives given during the 'counsel' phase of the interaction (ibid.) where the nurse would give recommendations for treatment
- Other requests – a small number of requests were related only to small talk

In the following chapter request strategies will initially be identified and then the use of internal and external modifiers will be discussed, following Faerch and Kasper (1989) (section 7.2) This is followed by the typical phases involved in taking blood, as this procedure involved a large number of requests and was highly transactional. The following section reviews potential individualisations of requests and compares the language of specific nurses. Section 7.4. looks at potentially patronising features that occur in the requests in my data and questions whether these features, and their usage, are patronising at all (i.e. perceived as such).

7.2. Request Forms

In the following table one can see the distribution of the types of requests used using Aijmer's (2014) typology (as discussed in section 4.4.1).

Table 15: The number of requests according to Aijmer's (2014) typology cross-cut with the styles of requests within medical settings

	Opening Sequence	Procedure Related	Follow Up	Other	Total
Ability	1 (1.7%)	21 (4.8%)	1 (0.5%)	2 (18%)	25 (3.6%)
Appropriacy	0	0	1 (0.5%)	0	1 (0.1%)
Clipped form	0	17 (3.9%)	7 (3.8%)	0	24 (3.5%)
Declarative	0	18 (4.1%)	2 (1%)	0	20 (2.9%)
Existence	0	12 (2.8%)	1 (0.5%)	0	13 (1.9%)
Hypothesis	1 (1.7%)	24 (5.5%)	42 (22.7%)	1 (9%)	68 (9.8%)
Imperative	48 (81.3%)	210 (48.2%)	82 (44.3%)	5 (45%)	345 (50%)
Naming	0	3 (0.7%)	3 (1.6%)	0	6 (0.9%)
Need	0	6 (1.4%)	0	0	6 (0.9%)
No verbal request	0	5 (1.1%)	0	0	5 (0.7%)
Obligation	0	11 (2.5%)	21 (11.4%)	0	32 (4.6%)
Other	8 (13.5%)	13 (3%)	4 (2.1%)	0	25 (3.6%)
Performative	0	0	5 (2.7%)	0	5 (0.7%)
Permission	0	30 (6.9%)	2 (1%)	2 (18%)	34 (4.9%)

Let us	0	38 (8.7%)	2 (1%)	1 (9%)	41 (5.9%)
Possibility	0	3 (0.7%)	4 (2.1%)	0	7 (1%)
Preference	0	2 (0.5%)	1 (0.5%)	0	3 (0.4%)
Willing	1 (1.7%)	23 (5.3%)	7 (3.8%)	0	31 (4.5%)
Total	59 (8.5%)	436 (63%)	185 (26.8%)	11 (1.6%)	691

Clearly the use of direct requests (imperatives) is the most frequent for all the requests with a significance p value of 0.00 (FET), this is similar to findings in my previous study of GP nurses (Lunan, 2010), in which I argued that the nurses use on-record directives to make their wants clear and concise, leaving no ambiguity in the mind of the patient.

On record, direct requests are not generally deemed to be the most polite in British culture, in fact, according to Blum-Kulka (1987, p.139) they are seen as the least polite. However, polite imperatives do exist (Aijmer, 2014) and can be softened by a number of mitigating devices, discussed in the following section. A large amount of the imperatives used are beneficial to the hearer, especially those made during the opening sequence and therefore the imposition may not be seen as heavy (ibid. p.184) if an imposition at all. Examples of such are:

- 'keep pressing that' (N3 Transcript 27)
- 'have a seat' (N9 Transcript 81)
- 'Come on in' (N1 Transcript 8)

The first example benefits the patient as if they press the cotton bud to their arm, the bruising will not be as severe. The nurse knows this, but the patient may not, which could cause this imperative to be more threatening than the others listed above. Requesting the patient to 'have a seat' obviously benefits the patient as it improves their comfort, while the directive 'come on in' meets the patient's goals of having a consultation with the nurse.

The second most common structure is *let me/us* or 'permission questions', especially in procedural requests. Examples of such are:

- Let's have a little look at your other arm (N3 Transcript 23)

- Let's untuck it at the front ((referring to shirt)) (N6 Transcript 60)

- Let me just show you how to do it (.) we take that slip off (N8 Transcript 71)

Aijmer (1996, p.163) argues that 'let me/us' can be compared to conventionally indirect forms, as 'can I' creates the same illocutionary force when swapped. Kohnen (2004, p. 172) furthers this by stating that this form 'invokes a strategy of approval (involving the ability or volition of the addressee)' in his study of the history of this form. The usage of 'let me' is argued by Kohnen as being polite as it seeks not to impose, thereby protecting the hearer's negative face (ibid., p.171) and making the request sensitive to the hearer's negative face wants.

When the request is constructed as 'let us', instead of 'let me', it is difficult to know whether the nurse is using the first person plural to refer to him/herself and the patient or him/herself and the other hospital staff. Ukaji (1978, p. 120) believes that 'us' refers to a group of people involving the speaker, the hearer and others. This would suggest that possibly everybody is being referred to by this usage. When analysing this structure, Brown and Levinson suggest that the usage of the plural is an attempt to gain reflexivity and is therefore a positive politeness strategy. However, De Clerck (2004, p. 231) argues that *let me* 'can give the impression of actually looking for or asking for agreement, whereas when one uses the 'convival' *let's*... agreement is taken for granted and can be taken as a starting-point to proceed with the proposed action.' I would argue that the nurses do have more power than the patients, but the use of 'us' suggests the hearer and speaker are working in a partnership together, something that is consistent with Culpeper and Archer's (2008, p. 68) finding that '*let's*' was commonly used among friends.

Follow-up related requests revealed some interesting patterns as the majority were, once again, imperatives, for example:

- Just cut your portion sizes down (N1 P1)
- Just put that on (.) well not more than three times a day (N5 P50)

Once again, these requests benefit the hearer as the patient has come to the nurse with an ailment and these requests inform the patient of the ways in which they can improve their health. In using direct requests, such as imperatives, the nurses are relaying the information in a straightforward and clear manner, this form of construction might avoid confusion. There is some mitigation, with the use of the minimiser 'just', which could imply the small amount of action needed by the patients to improve their health. Lakoff (1989: 102) states that 'the more a discourse type is designed for sharing of information, the less important politeness will be' and this could explain the use of direct imperatives in these types of requests.

Hypothesis requests were the second most frequent for follow-up care. The nurse would make suggestions for treatment if the patient's situation changed, for example, 'if things get worse (.) change (.) anything appears then please come back' (N6 P54). As with the majority of the requests found in the data, these may not threaten the face of the patient, but instead enhance the patient's face (Leech, 2014) by showing interest and concern.

Finally, obligation requests were the third most common, such as, 'you do need to make an appointment for your chest' (N1 P4), which seem to be used by the nurses to stress the importance of the actions that the patients must take in their follow-up care. Similar to imperatives, the use of modals of obligation creates a straightforward and easy-to-follow request that also highlights its importance. The use of obligation requests being used more frequently in follow-up requests could enhance the importance that the patient carry out the action. The action would be completed by the patient away from the consultation and therefore compliance may be less likely.

As previously mentioned, imperatives are not usually seen as particularly polite requests, similar to need requests, but the mitigation of directives can lessen the potential face threat. I will look at how the nurses use mitigation in the next section.

7.2.1. *Modifiers of Requests*

The previous analysis identified that imperatives were the most frequently used forms of requests. If relying on numbers alone, one could assume that the nurses do not use much politeness when uttering requests. This would be a naïve conclusion, however, as the nurses use a high number of mitigating devices, making the imperatives and requests as a whole 'polite' (Aijmer, 2014). (As previously noted, the majority of these are also uttered for the patient's benefit.) Below is a breakdown of the modifiers used with the directives for each style of request in my data, following Faerch and Kasper (1989).

Table 16: Internal and external modification used for each type of request

MODIFICATION		Opening	Procedure related	Follow up
Internal	Hedging	0	8	17
	Incurring a debt	0	44	1
	Minimizations	3	138	29
	Politeness marker	0	18	2
	S & H included	0	23	3
	Total	**3**	**231**	**52**
	Percent of modifications for 'style'	**6%**	**50.80%**	**29.38%**
External	Compliment	0	0	1
	Grounder	0	32	54
	Laughter	0	5	4
	Pre-request Question	0	8	3
	Total	**0**	**45**	**62**
	Percent of modifications for 'style'	**0%**	**9.89%**	**35%**

No Modification		48	135	48
	Percent of modifications for 'style'	**94%**	**29.67%**	**27.12%**
Other		0	44	15
Total		**51**	**455**	**177**

From table 16 we can see that opening sequence requests barely contained any modification at all with a significance of 0.00 (FET p value); once again, this can be attributed to the requests benefiting the hearer. It must be noted that requests such as 'sit down' and 'come in' do not fit within Brown and Levinson's framework as a face threatening act is not occurring. Rather these requests are examples of Leech's pos-politeness or face enhancing acts (2014, p.100) as the requests express a polite belief that is in favour of the hearer/patient.

Fifty percent of the procedure related requests used internal modification (a significant result, p=0.00 (FET)), most typically minimizations such as 'just' and 'little'. *Just* can be classed as a minimiser as Lee (1987, p. 383) states that just implies 'that the action involved is a relatively unimportant one – that it will perhaps involve little effort.' The use of these adverbs and adjectives are assumed to cause the negative face imposition to be minimised (Brown & Levinson, 1987). As the nurses are asking the patients to carry out physical tasks for them, the nurses utterances seem to commonly minimise the imposition making the task seem smaller. Through minimising these impositions the nurses conversational turns are constructing a more relaxed atmosphere.

Almost 30% of procedure related requests and follow up requests contained no mitigation whatsoever. This could imply a lack of politeness, but I will look at a number of these instances in context to see whether this is truly the case. The first extract is from transcript 38, an older female patient with an older female nurse. The nurse requests the patient to breathe into the spirometry machine.

Extract 38: Transcript 38

> 1.P: excuse me ((P blows nose (3.2s))) it's just so that I can hear more than anything ((sniffs)) (5.3s) ((N focuses on getting machine ready))
>
> 2.N: so (.) so (.) when you're ready (.) **deep breath in (.) tube in your mouth (.) and blow nice and steady but for as <u>long</u> as you can**
>
> 3.P: right
>
> 4.N: to keep it going
>
> 5.P: I've got you
>
> 6.N: ok (3.6s) ((P breathes in and starts exhaling into tube))

In this example the nurse uses imperatives and clipped forms with no mitigation other than to tell the patient to do the action when she's ready. Due to the three requests following each other it appears as though little mitigation is used. The effect of this is that the directives are clear, concise and easy to follow, similar to the findings of Mulholland (1994), who found chains of directives in doctor-patient interactions. The patient accepts the requests and instructions by uttering 'right' and the nurse adds more information in turn 4. The patient expresses her understanding in turn 5 and carries out the request afterwards. This is a common occurrence throughout the data; another example can be found in transcript 85.

Extract 39: Transcript 85

> 1.N: **arm straight (.) clench your fist**
>
> 2.P: I'm no good with needles so I'll just look away ((laughing voice))
>
> 3.N: oh just look the other way
>
> 4.P: yeah I will do

Nurses appear to use a chain of requests during procedures to get the patient to act out a number of tasks in sequence. This could be specific to health care settings.

Finally, follow up requests had a much higher percentage of external modification (35%), more specifically a high usage of grounders or reasons. This finding is unsurprising as whilst giving recommendations for treatment and general follow-up advice one would expect nurses to give reasons for the recommendation as it is part

of their role as a healthcare provider. For example, 'so you need to go back and see him (.) don't you (.) because we don't want it to be as high as that' (N8 P80).

Overall, I have identified three specific types of requests that occur in nurse-patient interactions: opening requests, procedure related requests and follow-up requests. The iterations of these requests seem to differ; although all three are most commonly imperatives, procedure-related requests were frequently structured as 'let's' requests, whereas follow-up requests, which required the act to be carried out after the consultation, were commonly formed as hypothesis and obligation requests involving a large number of grounders. This was unsurprising as the nurse could stress the need for the action to be completed in the future and further this with reasons for compliance.

My quantitative research also uncovered a large percentage of unmitigated requests during all phases of the interaction. I suggested that this could result in a clearer, less ambiguous directive, possibly preventing misunderstandings. A lack of redress could also be due to the requests benefitting the hearer (especially in opening interactions). However, the number of imperatives used could be reflective of the nurse's power, their need to complete the task quickly and effectively and, potentially, an indication of patronising talk. I will return to this issue in section 7.4.3, when I look at the use of imperatives with younger vs. older patients.

7.2.2. *Blood-taking Process*

Blood-taking was the most common procedure in the transcripts, with 39 interactions involving a blood test. The World Health Organisation notes that it is 'one of the most common invasive procedures in healthcare' (2010, p. xiii). Blood tests led to a large amount of requests and were of a highly transactional nature and so I chose to look at the typical stages that were involved when taking blood and how nurses framed these different stages. Some nurses did not do any blood tests, such as nurses 4, 5 and 6, whereas others, like nurse 3, did them almost exclusively. The following table shows a breakdown of the interactions involving blood tests and the nurses who carried them out.

Table 17: The number of interactions involving blood tests for each nurse

Nurse	Number of blood tests recorded
N1	2
N2	7
N3	9
N7	3
N8	8
N9	7
N10	3
Total	39

There were a number of typical communicative stages for taking blood that included requests, which will be analysed in more depth later on in this section. The stages were as follows, with the number of instances in square brackets:

1. Notification that a blood test was taking place – this was typically done at the beginning of the consultation and was manifested in a number of ways.

    [34 out of 39]

    a. As a statement (We're doing bloods today P12)
    b. Asking for a blood form (Do you have a blood form for me? P26)
    c. As a tag question (We're going to do a blood test today for you, aren't we? P86)

2. The nurse requesting the patient roll their sleeves up OR the patient rolling their sleeves up themselves e.g. (Can you just roll your sleeves up for me? P72)

    [15 out of 39]

3. Asking the patient to position their arm so the nurse can see the veins e.g. (Pop your arm on there P13)

    [22 out of 39]

4. Asking the patient to pump their wrist or make a fist e.g. (Can you make a fist for me? P81)

    [22 out of 39]

5. Requesting the patient to press hard on the site to reduce bruising e.g. (press on that nice and hard P21)

[26 out of 39]

6. Asking if the patient can wear plasters e.g. (Can I pop a plaster on? P71)

[5 out of 39]

The process of taking blood can be seen as an activity type (Levinson, 1979, 1992) – a culturally recognised activity that is made up of 'goal-defined, socially constituted and bounded events with *constraints* on participants, setting, and so on' (1992, p. 69). Taking blood has constraints on the interactants as one participant has to be a trained medical professional, and there are often, but not always, constraints on the setting, for instance the setting within my data is the GP surgery, but blood can also be taken within hospices and patients' homes. Levinson elaborates on her definition of activity types by stating there are constraints on contributions that the participants make that lead to strong expectations about the function of utterances and how they are understood. Constraints on contributions will be discussed further in the following sections when exploring the typical stages in more detail.

7.2.2.1. *Stage 1*

The first stage of the blood-taking process typically involved the nurse notifying the patient of the procedure. As stated previously, this was done in a number of ways. The following table shows a breakdown of how the nurses would introduce the procedure.

Table 18: Breakdown of how nurses introduced the blood-taking procedure

	Number of instances	Examples
Permission question	1	Can I just do some bloods for you? P71
Statement	10	We're checking kidneys with your blood P11

Tag question	7	We're going to do a blood test today for you, aren't we? P86
Asking for blood form	8	Do you have a blood form for me? P26
Inquiring about willingness	1	Are you alright with having bloods done? P30
Question	3	Are we just doing a blood test for you today? P81
'Let's' request	1	Let's do some bloods P77
Other	4	P: A spectator ((referring to researcher)) (.) oh she's wonderful (.) I can tell you that now N: (hh) that's only because I'm doing this blood test (hhh) P69
Stage did not occur	4	P17, P87, P88, P95

As can be seen from the table the most common introduction of the procedure was to make a statement. The second most common form were requests for a blood form and then tag questions. These ways of introducing the procedure are task-oriented and apart from the use of tag questions, removes patient autonomy. Healthcare literature highlights the importance of gaining consent for this procedure (Davidson & Bolton-Maggs, 2014; World Health Organisation, 2010. Further to this, the Royal College of Nursing argues that consent involves a verbal request for permission, such as 'Is it ok if I take your bloods now?' and state that if a nod, explicit verbal consent or a physical response do not follow, the nurse does not have consent to proceed (RCN, 2015). Despite this, the majority of the nurses do not appear to ask for consent from their patients.

There were, however, two instances that appeared to give the patient the option of having their blood taken (permission question and inquiry about willingness), although they may only serve as lip service as the patient would have come to the consultation knowing the procedure would take place. When looking at these two instances in context, the patient's reactions are interestingly the same. Both patients respond with humour rather than giving a real response.

Extract 40: Transcript 71 (Permission question)

1.N: ok (.) right (.) can I just do some bloods for you^
2.P: oh no (.) not blood ((smiling voice))
3.N: ok (.) let's have a look at your arms (1.5s) that one (.) ok (3.5s)

Extract 41: Transcript 30 (Willing request)

1.N: right (.) ok (6.9s) are you alright for bloods h-(0.8s)
2.P: sorry?
3.N: are you alright with having bloods done?
4.P: Oh god no (.) is someone having bloods done? (.) yeah no (.) I'm fine (hh)
5.N: (hh)
6.P: I'm fine with everything (.) I had injections in my eyes yesterday

In the first extract the patient responds negatively to the question, but the tone of his voice reflects the humour he wishes to convey. The nurse does not respond to his negative response, but her response suggests that she understands it to give permission as she uses a 'let's' request to choose an arm to take blood from. The second extract is similar in that the patient responds negatively to the request but expresses humour with laughter and exaggerated language 'oh God no'. The second patient does answer the question afterwards ('yeah no (.) I'm fine'), possibly implying that he understood that his response was ambiguous. The nurse's request in the second extract could also be deemed ambiguous as the nurse could be asking for permission and/or asking whether the patient has difficulty with taking bloods. The fact that both patients respond with sarcastic humour could reflect that they do not feel the need to be asked permission and are aware the request is mostly lip service. Suggesting that when patients come to the GP consultation knowing that they will have their blood taken their consent may be implied, making requests from the nurse redundant.

7.2.2.2. *Stage 2*

The second stage of the blood-taking process had patients rolling up their sleeves. This stage was not as frequent as others as some of the patients had already anticipated that they needed to roll their sleeves up. The nurses would also make this request by asking which of the patient's arms was preferred. The following table shows the ways in which this request was uttered and how often.

Table 19: Ways in which patients were requested to roll their sleeves up and number of instances

Ways in which patients were requested to roll up their sleeves	Number of instances
P does it themselves	19
P already had sleeve rolled up	2
Which arm is best?	4
let's request	4
Inquiry about willingness	2
'let me'	1
Ability	1
hypothesis	1

Evidently, the majority of patients anticipated the need to roll up their sleeves and the nurse didn't have to utter a request to get them to do so. This links to the notion of activity types as the patients use schematic knowledge to anticipate the desires and needs of the nurse, therefore rendering a vocal request unnecessary.

7.2.2.3. *Stage 3*

Stage three involves the nurse asking the patient to position their arm so that blood could be taken more easily. The raw frequencies and percentages of this stage can be found in appendix 5. Imperatives appeared to be used more with older patients when requesting them to move their arm (with 58%), whereas the nurses appear to use no

verbal requests slightly more with younger patients (52%). In this case, no verbal request meant that the nurse would take hold of the patient's arm and move it to the desired position. It seems quite striking that the nurses would make more verbal requests to older patients than to younger patients. In the literature, this would be seen as a sign of patronising language as the nurses are using more directives towards older patients, but moving a patient's arm without uttering a request could be seen as even more face-threatening as it is taking away the patient's autonomy; by uttering a direct imperative the nurses are allowing the patient to enact the movement themselves, and surely, this should be seen as less patronising.

7.2.2.4. *Stage 4*

In stage 4 the nurse would commonly ask the patient to make a fist or pump their wrist (this is a step noted in the WHO guidelines on drawing blood: best practices in phlebotomy (2010)). The stage was most commonly uttered as an imperative (44%), but was also frequently absent from the consultation (44%). The frequencies and percentage of this stage's usage can be found in appendix 5. There was no clear difference between whether the nurse used this stage with older or younger patients, but there were large differences in the usage of this stage between nurses. Nurses 3 and 8 used this stage in almost every procedure (with 6 out of 9 and 8 out of 8 uses respectively), whereas Nurses 2 and 7 did not tend to include this stage in the blood taking process (with 1 out of 6 and 0 out of 3 uses respectively). Further discussion of nurses 2 and 7's request styles can be found in section 7.3.1.

7.2.2.5. *Stages 5 and 6*

Stage 5 involved the nurse asking the patient to press hard on the needle site in order to reduce bruising. The following table shows how the request was typically uttered.

Table 20: Request forms of stage 5 of taking-blood process

Request	Number
Imperative	18
Need	1
Ability	4
Willing	1
Hypothesis	2
Stage did not occur	13

The request was rather frequent with 26 verbal iterations and was most frequently uttered as an imperative, typically softened via minimisers. For example, 'Just press hard on that' (N1 Transcript 4). It was generally used by all nurses, except nurse 7 (see table 21), who seemed to use a large amount of relation-oriented talk throughout the blood-taking process (see section 7.3.1).

Finally, stage 6 involved the nurse asking whether the patient would like a plaster. This was extremely infrequent, however, as it was only used by nurses 8 and 1 (see table 21). The following table shows how often each of the nurses made requests at each stage of the blood-taking process, reflecting that some nurses almost always used these communicative stages throughout the process, such as nurse 8, whereas others used very few (nurse 7). This could hint at individual practices and nursing styles, which I will discuss further in the following section.

Table 21: Overall nurse breakdown for each of the stages of the blood-taking process (the figures before the slash indicate the raw frequency of each of the stages and the figures after indicate the number of blood taking consultations for each nurse)

	N1	N2	N3	N7	N8	N9	N10	Total
Stage 1	2/2	6/7	9/9	3/3	8/8	5/7	1/3	34/39
Stage 2	0/2	3/7	5/9	0/3	6/8	0/7	1/3	15/39
Stage 3	1/2	6/7	7/9	0/3	5/8	2/7	1/3	22/39
Stage 4	1/2	1/7	6/9	0/3	8/8	4/7	2/3	22/39
Stage 5	2/2	6/7	8/9	0/3	3/8	5/7	2/3	26/39
Stage 6	1/2	0/7	0/9	0/3	4/8	0/7	0/3	5/39

Total	7/12	22/42	35/54	3/18	34/48	16/42	7/18	

Overall, this section has outlined the common communicative activities that occur when nurses take blood, such a process has never been outlined before in previous literature and could provide a base for further studies on this process and the communicative practices that are typically involved. My analysis has shown that this is not a strict taxonomy as the nurses seem to use some stages more than others and some nurses appear to use more relational talk and thereby skip stages (as shown qualitatively in section 7.3.1).

7.3. Individual Request Styles

7.3.1. *A Relational Approach*

Nurses 2 and 7 used fewer requests than the other nurses in the dataset with only 35 and 38 requests respectively in total throughout the 10 interactions. The average number of requests for the nurses was 81.3. I will now look at a few requests within their context to discover why these two nurses use so few requests.

Extract 42: Transcript 16

23.N: Ohhh (.) have you had your lunch? (.) what have you had for lunch?
24.P: Today?
25.N: Yeah
26.P: I had=
27.N: =Did you make it?
28.P: I had cheese on toast but I have carers now
29.N: Oh yeah
30.P: And I get (.) meals delivered
31.N: Oh that's wonderful
32.P: from Winter foods=
33.N: Do you have to pay for that?
34.P: Yes (.) but they're not dear

| 35.N: Are they not? (.) **Turn over** ((P turns arm over)) |
| 36.P: And I have one every night so I don't have to cook |
| 37.N: How fab's that? What do you get? A roast dinner and stuff? |

In this interaction the nurse and the patient are talking about what the patient had for lunch. The nurse introduces the topic by asking the patient and showing interest in her (line 23). The phatic talk continues until line 35 when the nurse asks the patient a question about her delivered meals and then orients towards the task at hand by requesting the patient to 'turn over'. The request is on-record without any mitigation. This would be consistent with the small imposition of the request, as noted by Brown and Levinson (1987). It is also possible that using the shortest, most economical politeness forms has the benefit of allowing the patient space to do their phatic talk.

This same occurrence takes place multiple times throughout the interactions with nurse 2 and her patients. It does not always occur with patients she is familiar with, in fact, it appears in one interaction when she has never met the patient before and another where she has only met the patient once before, for example:

Extract 43: Transcript 19

| 28.P: but I have got a twin brother |
| 29.N: Have you? I've got a twin sister |
| 30.P: Seriously? |
| 31.N: Yeah (.) Is he here as well? |
| 32.P: No he's not (.) he's in the he lives down south |
| 33.N: Awww (.) Identical I take it? |
| 34.P: Well yeah (.) if you'd seen him you'd think he was me since I work in the. post office= |
| 35.N: [Oh right] |
| 36.P: =and he comes up to see me and felt like I'm two Paul's |
| 37.N: **Press down** (.) I'm like that with mine |
| 38.P: Are you alike? |

In this instance the two have just discovered that they are both identical twins and both show interest in the fact. The discussion of their twins continues for the rest of the consultation. Nurses 2 and 7 clearly seem to take a more explicitly relational approach to the consultation rather than a transactional one.

Nurse 7 is similar to nurse 2 in that she does not use many requests and takes a more explicit relational approach to the consultations. Her requests do differ though, as she does not typically voice her procedural requests to the patient, staying in a social frame rather than switching between a medical frame and a social one. This can be witnessed in the following extract:

Extract 44: Transcript 66

> 1.N: yeah (.) that's it (1.2s) right (.) **so we'll do the blood tests (.) now** (4.0s) so are the family well?
> 2.P: mm (.) sadly not no
> 3.N: oh^ ((moves Ps arm))
> 4.P: me daughter (.) the middle one's had a baby

In this extract the nurse uses a declarative statement rather than a request such as 'can I do your bloods now?'. In addition, throughout the procedure she moves the patients arm without uttering a request whilst maintaining the conversation about the patient's family, which continued for over 124 turns until the nurse uttered 'N: yeah yeah (.) <u>right (.)</u> now then (.) that's that (.) going to plaster on that (.) and you're seeing (doctor name) aren't you^'. The other nurses in the dataset would commonly ask the patient to move their arm, for example, P13 'N: Pop your arm on there'. A similar situation arises in transcript 63.

Extract 45: Transcript 63

> 1.P: so (.) traffic round there is a (.) incredibly bad
> 2.N: might (.) it only needs something and the whole place (.) gets (4.5s) **I'll try the syringe on your hand there** ((1.5s N takes P's hand)) we're having some new (.) equipment to do bloods so:: (.) I don't know what that's going to be like
> 3.P: you can test it out on me

4.N: yeah (hhh) oh nothing coming is there (0.9s)

5.P: I know they're deep because I=

6.N: =yeah

7.P: when I did give blood (.) they were always having trouble (.) yeah

8.N: were they^ (1.5s) no (.) failure this morning (.) isn't it^

9.P: have you seen that ((to R))

10.N: failure this morning ((laughing voice))

11.P: here we go (1.9s)

12.N: **alright (.) we'll try this ((takes hand)) they're not that brilliant either (.) are they^(1.4s)**

13.P: they are there

14.N: (hhh)

15.P: I am alive

16.N: somewhere (1.1s) see most people have them (2.0s) alright (.) this'll hurt (23.5s) oh

17.P: have you got some^

18.N: I've got some but it's very very slow (1.3s)

19.P: I'm not looking (hh) (2.6s)

20.N: are the family well (.) or

21.P: oh yeah (.) they're fine (.) it's half term

22.N: (hh)

In the following excerpt there are two instances where the nurse could have made a request such as 'can I try your hand?', but used a declarative statement instead, therefore removing the patient's options. By making fewer requests of the patients during the procedure the nurse could be seen as reducing patient-centredness by not taking the patient's wishes into consideration and by asserting her power over them. However, the lack of directives and large amount of social talk could have a positive effect on the patients, as they commented:

- She's excellent (.) she's easy to talk to (.) she's interested and knowledgeable (.) she's the best of the lot (P66)

- It's always fine with (N first name) she makes me very comfortable (.) it's just the fact that she's got a nice manner, [when asked about knowing the

nurse for a long time he said:] well that helps but she's been like that since I first met her (.) it's not developed it's always been that way (P63)

These two nurses both had extremely positive evaluations from their patients, nurse 2 would also receive mentions from patients who had had a consultation with one of the other nurses from the first surgery. This would suggest that by taking a more individual approach to caring for the patient, by making small talk, and furthering it, the patient may leave feeling more satisfied with the consultation.

7.3.2. *Individual Framing of Requests*

Analysing the usage of requests and the ways in which the nurses mitigate them made particular patterns emerge. The following table shows the different usages of requests and mitigation by two of the nurses that showed individual traits, nurse 2 and 3.

Table 22: Table of individual requestive strategies for nurses 2 and 3

	Nurse 2 Older	Nurse 2 Younger	Total	Nurse 3 Older	Nurse 3 Younger	Total
Requesting blood form	0	0	0	4 (57%)	3 (43%)	7
Let's/let me structures	1 (33%)	2 (66%)	3	10 (71%)	4 (29%)	14
Minimisation usage	4 (44%)	5 (55%)	9	23 (59%)	16 (41%)	39
Usage of 'nice and'	0	0	0	7 (50%)	7 (50%)	14
Terms of endearment and first names	17 (65%)	9 (35%)	26	0	0	0

The table above shows a number of different features used by the nurses. It is, however, important to note that Nurse 2 did use fewer requests than Nurse 3 overall – and could have led to differences in the usage of minimizations. The nurses both

had similar appointments of taking blood and giving injections, but they seem to have different consultation styles, which can also be found in the use of small talk and humour. Nurse 2 would appear to construct more of a conversational and rapport building approach as she uses a large number of terms of endearment, first names and fewer request structures (discussed in the previous section). The requests she uses typically interrupt the phatic talk that is occurring between herself and the patient and the talk is immediately oriented back to non-medical discourse after the interruption.

Contrastingly, Nurse 3 uses a large number of requests with both younger and older patients. In almost all of his interactions in the data he uses an 'existence' request (Aijmer, 2014) to obtain the blood form from the patients (e.g. 'do you have your blood form?' and 'have you got your blood form with you?') at the beginning of the consultation. Although Nurse 2 does a number of blood tests, she never requests the blood form. The data does not account for why this might be the case. However, it could be due to the amount of time the nurses were working at the practice. Nurse 2 had been at the practice for a number of years, whereas Nurse 3 was only eight months into the job and could have still been doing everything 'by the book'. Nurse 3, although having met three of his patients before, did not use any first names or terms of endearment within his requests, suggesting and possibly constructing a greater distance between him and his patients, unlike Nurse 2 (who used them even with patients she had never met before).

Finally, Nurse 3 used the device of 'nice and..' which has not appeared in any of the literature on requests. The number of times that he uses this feature (14) makes it appear as though it is a part of his request style as although it was used 3 times by nurse 4 to describe breathing, it was not used by any other nurse. Examples of requests using this device are:

- Just keep pressing that nice and hard
- Pump your wrist like that (.) nice and big
- Keep nice and still

It is interesting to note that it is always posed as a word pair with "nice" functioning as an intensifier of the quality of the action that is considered desirable. It is not really mitigating the request, but boosting it. One could consider this device as a value laden booster.

This section has suggested that requests used by nurses cannot be assumed to be homogenous. The nurses throughout my dataset appear to have specific styles that they adopt within their consultations, which could reflect their personalities. Both nurses 2 and 7 appear to reduce patient autonomy through a lack of requests, which could be seen as contrary to a patient-centred approach, but the amount of social talk in their consultations shows individual care and interest in the patients that they are talking to, thereby creating a patient-centred approach to nursing after all.

Finally, it was discovered that nurse 3 used a new form of modification that has not, as yet, been reported. The nurse uses a value laden booster to intensify the quality of the act, potentially to ensure adherence.

7.4. Patronising Language in Requests

Patronising language is the modification of talk to accommodate to the 'perceived communication needs of another' (Nussbaum et al., 2005, p. 289), specifically when the speaker believes the hearer has low functionality or is helpless (Atkinson & Sloan, 2017, p. 288). This has been reported to occur in elderly healthcare settings as a result of ageist stereotypes. The literature on patronising talk/secondary baby talk has identified a number of discourse features which appear more frequently in spoken interaction with older adults. A selection of these include a higher usage of imperatives, terms of endearment and diminutives, collective plural pronouns, high frequency of tag questions and frequent praise (Brown & Draper, 2003; Grainger, 1993; Makoni & Grainger, 2002; Marsden & Holmes, 2014). These have been selected as they tend to occur within and around requests. Hummert et al. (1998), Hummert and Ryan (1996) and Ryan et al. (1995) argue that even a subset of these patronising features can create a message that is deemed inappropriate by the older recipient. Within this section I intend to test this by analysing the use of these

features with both younger and older patients in order to ascertain whether nurses, in this setting, talk to younger and older patients differently. Although the features may be present, and potentially increased in use, this does not necessarily mean that they are patronising as the hearer's perception needs to be taken into account. Unfortunately, throughout the literature this key perspective is missing and the literature involved relies on understandings of others (for example, Caporael (1981)) rather than the participants involved in the interaction.

7.4.1. *Tag Questions*

There were relatively few tag questions in the data. They were typically used to check the reasons for the patient's visit such as 'we're doing a blood test (.) aren't we?' (P20), to confirm previous health related actions 'you've had your flu injection (.) haven't you?' (P66) and to further phatic communication:

> P: right (.) it was good that we were getting quite a few orders through that and everything that we said (.) look it would be better to have an outlet because it's got a kitchen and everything
>
> N: yeah yeah (.) you need it (.) don't you? (P29)

However, there was one instance of a request involving a tag question that could be seen as potentially patronising due to the context and the prosody involved. The following excerpt comes from transcript 77:

Extract 46: Transcript 77

1.N: it is (.) do you want to take your jacket off Mr (last name) and we'll pop that there

2.P: as long as you don't start kicking me out (.) that's the main thing

3.N: yeah (.) we'll have you (.) I'll pop your jacket on there (.) will you take this (.) do you want to^

4.P: aye I will do

5.N: well I'm going to do bloods and stuff (.) we may as well take them all off now (.) mightn't we

| 6.P: you want to |
| 7.N: get organised (.) eh^ |

The nurse starts the first request by asking if the patient is willing ('do you want') to take his jacket off. She then starts to ask him if he will take his jumper off, but doesn't finish either iteration of this request (will you take (1), do you want to (2)) this may be because she does not want to request too many things from the patient. He accepts her request to take his jumper off without her needing to verbally complete the request as he has understood what she wanted him to do. In turn 5 the utterance is mitigated with a grounder, a plural pronoun 'we' and a tag question 'mightn't we' to include both participants in the action. Further grounding is added in turn 7 with the phrase 'get organised'. This section of the recording could be seen as patronising as the nurse's conversational turns involve a number of discursive features that make up elderspeak, for example, the use of plural pronouns and tag questions. The prosody of turns 5 and 7 is interesting as it would be expected that the tag question would show a rise in pitch, but the nurse's pitch remains similar throughout the whole turn. An increase in pitch is seen in the seventh turn as the nurse seeks agreement from the patient with the sound 'eh'.

Although aspects of this turn could be seen as patronising, the patient did not evaluate any of the interaction to be. He stated in the interview:

> [she was] very friendly and acceptable (.) uhh I think it was just a general professional manner (.) patient and friendly…if she treats everyone like that then that's first class

This shows that patient perspective is important in gaining an understanding of what is perceived as patronising talk. Although the sequence had various features that can be seen as patronising, the hearer's interpretation of the language used is key.

7.4.2. *Terms of Endearment*

Terms of endearment are commonly listed as a feature of patronising talk (Backhaus, 2009; Grainger, 1993), but this discursive feature could be more of an individual trait than a sign of condescension. The dataset revealed only 23 instances of terms of endearment used by nurses, 21 of which were used by the same nurse, Nurse 2. The following table shows the terms of endearment used by the nurses with information about the patients.

Table 23: Terms of endearment used by the nurses cross-referenced with patient information

Patient	Terms of endearment used	Patient age	Patient Frequency	Patient Sex
P11(N2)	lovely	Younger	Not seen before	Male
P12 (N2)	Honey X2, darling, lovely X3	Older	Once or twice	Female
P13 (N2)	Love, honey X2, darling, lovely	Older	Frequent	Female
P14 (N2)	Lovely X2	Younger	Frequent	Male
P15 (N2)	Lovely, love	Younger	Once or twice	Male
P16 (N2)	Lovely, love	Older	Frequent	Female
P18 (N2)	Lovely	Older	Frequent	Female
P19 (N2)	Lovely, love	Younger	Once or twice	Male
P38 (N4)	Love X2	Older	Not seen before	Female
P83 (N8)	Lovey	Older	Once or twice	Female

Nurse 2 most typically used terms of endearment with patients that she had seen before and used them with a mixture of younger and older patients, although she did use a larger amount with patients 12 and 13, both of whom were older. The context of these utterances is important as it is key to ascertain whether they function to mitigate requests by being 'superficially relation oriented' (Grainger, 1993, p. 256) or solidarity building, as found in Marsden and Holmes' (2014) research.

N: Come on (.) fist again **honey [1]** (.) just do fist again (.) just trying to pump it up a little bit (.) you can feel it there (.) sharp scratch **darling [2]**

……

N: I'm just going to ummm (.) nice and straight like that (4) sting **lovely [3]** (.) no (.) not playing (.) have you had much water today?

P: I've just one cup of tea

Extract 48: Transcript 13

N: Just the routine bloods (.) isn't it? (1.6) (first name), are you alright **lovely? [4]**

…..

P: He might do yes (.) no (.) I'm not going to try (hhhh)

N: Got enough of your own haven't you **love [5]**

P: Yeah

N: Press down really hard **honey [6]**

P: Yeah (.) yeah John (hh)

Extract 49: Transcript 15

N: yeah (.) lovely (.) super duper (.) thank you ((takes form)) **right lovely [7]** which arm is it?

P: ummm (.) take your pick I suppose

Extract 50: Transcript 19

N: Right **love [8]** (.) you're all done

P: Sorted

In these extracts it can be noted that the terms of endearment are used during different speech acts. The nurse uses terms of endearment during openings and closings as seen in examples 4 and 8 (numbered in square brackets in extracts), they function to mitigate requests in examples 1 and 6, to soften 'bad news' in examples 2 and 3 and to relationally orient talk in example 5. By using terms of endearment during openings and closings and relationally oriented talk the nurse's utterances could have the effect of gaining solidarity, especially as the nurse uses these features

with both younger and older patients. The examples suggest that terms of endearment are not always used to gain cooperation from the patient (and in doing so implicitly attributing power to the nurse), but can also function to gain solidarity, as Marsden and Holmes (2014) found in their study of elder talk in New Zealand residential care homes. Further to this the interviews with the patients were all extremely positive with patient 13 saying 'she's very polite and caring, she's not formal, she always calls me (first name) which makes a difference and I think that helps' and patient 18 commenting that 'she's wonderful…lovely and friendly, she's very kind and interested, she's the perfect nurse'. Evidently the use of terms of endearment did not negatively affect the way the patients evaluated the nurse and could possibly have influenced their evaluation that she is 'caring' and 'interested'.

Nurse 2 almost always uses terms of endearment with her patients. It was noted that she did not use any with patient 17, after which the nurse commented to the researcher 'she was a bit off, wasn't she?'. This could be a sign that terms of endearment for nurse 2 are a way in which she shows affection with her patients. A further investigation into nurse 4's use of terms of endearment reveals an interesting case of reciprocity.

Extract 51: Transcript 38

> 1.N: (hhhhh)
> 2.P: everyone won't be as daft as me (.) love (.) don't worry
> 3.N: you're not daft at all love (.) you're fine
> 4.P: you've got to make light of things (.) haven't you?
> 5.N: you have (.) yes
> ……
> 6.P: am I done then?
> 7.N: you are love (.) yeah
> …..
> 8.N: right (.) well done
> 9.P: that's what I need (.) bye darling
> 10.N: thank you
> 11.P: thank you

| 12.N: bye |
| 13.P: bye my love (.) thank you |

In the extract the patient uses the term 'love' to refer to the nurse first and the nurse then reciprocates the term immediately. It seems that once the patient introduced a term of endearment the nurse then felt comfortable using it with her as the patient had set the tone. This can be evidenced in turn 7 as the nurse uses a term of endearment to close the interaction. As Marsden and Holmes (2014, p. 25) argue 'reciprocal usage of endearments suggests an equal and friendly relationship' and this certainly seemed to be the case in this interaction, as the patient noted in the interview 'I loved it [the consultation]…she was lovely, very kind and caring…[and] it was good that everyone was laughing, it was like we were all having a good time'.

Despite terms of endearment commonly being understood as a form of patronising language (e.g. Backhaus, 2009), the reality is not so simple. The nurses in this setting seem to use terms of endearment to gain solidarity, especially in the case of nurse 2. As Marsden and Holmes (2014, p. 24) notes terms of endearment 'need to be interpreted on an individual basis in light of particular contextual factors, and especially with reference to the personalities and personal relationships of the participants.'

7.4.3. *Imperatives*

A higher usage of imperatives with older patients is purported to be a typical feature of patronising talk (Brown & Draper, 2003). Within the data there were 705 instances of directives (all forms of requests), 380 of which were aimed at older patients and 325 at younger patients. The following table shows the distribution of request types with older and younger patients.

Table 24: Distribution of request types with younger and older patients

	Older Patients	**Younger Patients**
Imperative	**193 (51%)**	**148 (45%)**

Other request form	187 (48%)	177 (55%)
Ability	16	9
Appropriacy	1	0
Clipped form	15	9
Declarative	9	14
Existence	5	8
Hypothesis	28	43
Let us	27	17
Naming	4	3
Need	2	4
No verbal request	0	7
Obligation	18	15
Other	16	10
Performative	0	5
Permission question	20	16
Possibility	4	3
Preference	2	1
Willing	20	13
Total	**187**	**177**

As stated previously, imperatives were the most frequent form of request, but there was a slight difference in the number of imperatives used with older patients than younger patients. However, this difference was not statistically significant (FET p=0.42). This would suggest that nurses do not use significantly more imperatives with older patients than younger patients. I decided to look at imperative usage in more detail to uncover whether there were differences in the three styles of requests in medical settings, this can be found in the following table.

Table 25: Imperatives used in each style of request

	Older Patients				Younger patients			
	Opening	Procedural	Follow up	**Total**	Opening	Procedural	Follow up	**Total**
N1	2 (18%)	4 (36%)	5 (45%)	**11**	0	4 (29%)	10 (71%)	**14**
N2	0	8 (80%)	2 (20%)	**10**	2 (22%)	7 (78%)	0	**9**
N3	4 (17%)	18 (75%)	2 (8%)	**24**	1 (5%)	18 (90%)	1 (5%)	**20**
N4	1 (3%)	37 (95%)	1 (3%)	**39**	1 (3%)	23 (79%)	5 (17%)	**29**
N5	5 (5%)	13 (68%)	1 (5%)	**19**	2 (9%)	4 (18%)	16 (73%)	**22**
N6	5 (24%)	5 (24%	11 (52%)	**21**	1 (8%)	5 (38%)	7 (54%)	**13**
N7	3 (18%)	7 (41%)	7 (41%)	**17**	3 (43%)	1 (14%)	3 (43%)	**7**
N8	3 (17%)	13 (72%)	2 (11%)	**18**	0	6 (75%)	2 (25%)	**8**
N9	3 (15%)	14 (70%)	3 (15%)	**20**	3 (16%)	14 (74%)	2 (10%)	**19**
N10	4 (29%)	8 (57%)	2 (14%)	**14**	5 (71%)	2 (29%)	0	**7**
	30	**127**	**36**	**193**	**18**	**84**	**46**	**148**

The table shows that there is a clear difference in procedural requests and that nurses 4, 5, 7 and 10 seem to use more procedural imperatives with older patients than with younger patients. Nurse 5's procedural requests also showed a statistically significant difference (FET p=0.04). The nurses also appear to use more opening sequence imperatives with older patients than younger patients, almost double the number, although not statistically significant. In order to discover why there were more imperatives aimed at older patients I took a closer look at these nurses' interactions and the procedural imperatives made.

When looking at the procedural imperatives used with older patients compared to younger patients there did appear to be more repetition of requests with older patients, for example, N5 with patient 48 asked the patient to drop his shoulder on two occasions due to non-compliance from the patient:

Extract 52: Transcript 48

> N: so (.) **drop your arm** (1.5s) ((P does not respond)) ok (.) **drop your^ shou^lder**(0.9s) that's it

A similar example can be seen with patient 38 and Nurse 4 as she repeatedly asks the patient to stop breathing in the spirometry machine, a repeated request that is surrounded by a chain of requests (Mulholland, 1994):

Extract 53: Transcript 38

> N: so (.) no (.) you need to breathe in first (.) tube in your mouth (.) and blow into the tube ((P breathes into tube)) keep going keep going keep (.) right (.) **stop (0.3) stop (0.6) just stop** (.) so (.) when you blow it's one blow (.) [and then stop]

There were also more instances of a chain of requests occurring with older patients, for example, in transcript 38 and 41:

Extract 54: Transcript 38

> 2.N: so (.) so (.) when you're ready (.) **deep breath in (.) tube in your mouth (.) and blow nice and steady but for as <u>long</u> as you can**

> N: Ok ((N taps syringe and walks over to P)) OK **drop your shoulder** ((N drops
> shoulder to show P)) (.) **relax** (.) **pop it there** (.) and **think of something nice like
> strawberries and cream** or:::=

This could suggest a difference in the language nurses use with older and younger
patients, especially when carrying out procedures. One might speculate that the
nurses may repeat requests with older patients due to a potential perception of lack
of hearing. However, it is interesting to note the increased use of chains with older
patients. This could suggest that the nurses perceive older patients to need more
direction when carrying out procedures or even could hint at a belief of lower brain
functionality. Obviously, such possible motivations would need further
investigation.

7.4.4. *Praise*

There were 56 instances of praise that followed requests in the dataset. A breakdown
of the nurses who used praise can be seen in the following table.

Table 26: Use of praise with younger and older patients

	Older	Younger
N1	1	0
N2	2	2
N3	8	0
N4	17	9
N5	2	1
N6	1	1
N7	0	1
N8	2	3
N9	1	1
N10	2	1

Evidently, there are two nurses that appear to use more praise than others, nurse 3 and nurse 4. When looking at the context of the praise it was noted that nurse 4 would use a large amount of praise to both younger and older patients when doing a spirometry test that involved the patient breathing in a tube. They often had difficulties with this and the nurse would praise them for their efforts. The disparity in the amount of praise used with older patients and younger patients could easily be explained by the fact that fewer younger patients had to do this breathing test as four of the older patients needed a spirometry compared to only two of the younger patients.

Although the difference in consultation activity explains the differences found in nurse 4's use of praise this cannot be said of the differences in activity for nurse 3 as all of his consultations involved taking blood and administering injections. When taking a closer look at the requests used by nurse 3 that were followed by praise it became obvious that similar requests were being used with younger patients, but praise was added only with older patient requests. The following table shows a few examples of similar requests used with younger and older patients, demonstrating that praise is only used with older patients.

Table 27: Comparison of requests with praise for younger and older patients

	Older	Younger
Imperative	P25 N: Put your arm there ((on pillow)) **That's great**	P30 N: just pop your arms on there for me ((gives pillow))
Ability followed by imperative	P27 N: Can you straighten it? ((P straightens arm)) **that's it** (.) just pop that right down (.) **that's it** (2) just straighten it	P29 N: can I have a look at this arm first? (1.7s) just pump your wrist a bit for me (4.0s as P pumps wrist)

	down a bit more (.) **that's great** (4) ok (7) ok	

This difference in usage of praise by this nurse could hint at patronising behaviour as there is a marked difference in how this nurse responds to compliance of requests with older versus younger patients. However, once again the patients did not perceive the language of the nurse to be patronising. Patient 23, an older patient commented, 'he was very encouraging, welcoming, calming and he put you at ease…there was nothing condescending about it at all, it was just normal, person to person, one to one' and patient 27 stated 'I used to live in London and I've never had it before where there's nice service, but it's very nice here and he's very nice and puts you at ease'. The patients all expressed a positive experience from the nurse and evidently, the use of praise did not concern them so as to bring it up in the interview. However, the difference in usage could suggest a different approach used by the nurse with older versus younger patients.

7.4.5. *Collective Plural Pronouns*

Collective plural pronouns were used in 34 requests throughout the dataset and there were 44 'let's' requests. The following table shows the distribution of use of these collective plural pronouns.

Table 28: Distribution of collective plural pronouns

	Older		Younger	
	we	**Let's**	**we**	**Let's**
N1	3 (14%)	5 (19%)	3 (23%)	2 (12%)
N2	0	1 (4%)	3 (23%)	1 (6%)
N3	2 (10%)	8 (30%)	1 (8%)	3 (18%)
N4	5 (24%)	0	0	1 (6%)
N5	0	1 (4%)	0	2 (12%)
N6	3 (14%)	6 (22%)	1 (8%)	5 (29%)

N7	1 (5%)	1 (4%)	1 (8%)	1 (6%)
N8	4 (19%)	2 (7%)	0	0
N9	3 (14%)	3 (11%)	4 (31%)	2 (12%)
N10	0	0	0	0
Total	**21**	**27**	**13**	**17**

There are slightly fewer collective plural pronouns used with younger patients, for example nurses 4 and 8 use 'we' only with older patients and nurse 3 seems to use more 'let's' requests with older patients than younger patients. In section 7.4.5, we saw that the use of 'we' combined with a tag question created a potentially patronising utterance, although it was not perceived as such by the patient. The following table shows examples of requests involving 'we' from both N4 and N6.

Table 29: Examples of requests using collective plural pronouns with older and younger patients

	Older	Younger
N4	P31 N: because we're supposed to get it within a 5% change for it to be what we call reproducible so **we'll** see if **we** can get this next [within the fi-] P: [right (.) so try] the same again N: yeah (.) is that ok^	P34 N: you've got to try and do this within a 5% change so it's got to be exactly the same as what you've just done (.) basically (.) ok
N8	P80 N: right (.) so **we'll** stay nice and relaxed (.) think about nice holidays and=	P79 N: just umm (.) relax your hand for me (.) that's it

Nurse 4 uses 'we' when explaining the process of the spirometry with older patients. Every usage of 'we' by the nurse was connected to the spirometry test and trying to

get the patient to fulfil the requirements of this test. These utterances could have the effect of showing solidarity by involving both the hearer and speaker, but the use of 'we' could also be interpreted as an indication that the patient cannot act independently.

7.4.6. *An Example of Perceived Patronisation*

Over the previous sections I have detailed how a number of features that are supposed to typify patronising talk were not perceived as such by the patients. However, there was one instance in my data where an older patient perceived he was being patronised when the nurse informed him how to urinate in a sample pot.

Extract 56: Transcript 71

17. N: it's on a new system (.) ok^ (.) let me just show you how to do it (.) we take that slip off

18. P: (hhhhh)

19. N: put a bit of urine in there (.) you don't need an awful lot (.) ok (.) you take that off and all you do (.) put your name and date of birth on there and (.) I'll give you actually (.) I'll label it for you (.) and just plunge it in and it sucks it up like a suction and all we want back is that (.) so you can chuck this away (.) so you just put that in a (.) bag (.) I'll give you a bag and then that's it

20. P: I am a dentist

21. N: (hh) yeah^

22. P: I'm used to all these things

23. N: do you do these^

24. P: no we don't actually

25. N: no you won't do these (.) they're a new thing in the lab and we'll label this=

26. P: =so (.) will (.) will that mean I don't have to take that to the hospital^

……

36. N: alright ok (.) can you just slip your shoes off and just get on the umm

37. P: both of them?

> 38. N: yes ((9.5s N presses on scales to activate them, but they don't turn on))
>
> 39. P: didn't press hard enough (.) I even know how to work the scales ((smiling voice))
>
> 40. N: (hh) right (.) 117

The nurse starts by requesting the patient to pay attention while she shows him how to use the sample pot. The sample pots were new to the practice and involved a vacuum as opposed to the previous standard pot, which might explain why the nurse felt the need to explain to the patient how to use the new collection system. However, her explanation leads to the patient expressing in a number of ways that he felt he was being patronised. In turn 18 the patient starts to laugh at the idea of being shown how to urinate in the pot. His laughter may function to express discomfort (DuPre, 1998; Grainger, 2004b) and even possibly to express frustration (Wender, 1996). Despite the patient's laughter, the nurse did not pick up on his signals that he did not need to be informed of how to use the pot and continues to give him intructions in the following turn. He responds to the instructions, appearing to flout Grice's maxim of relevance (Grice, 1975), with 'I am a dentist'. The patient here seems to be relying on implicature to suggest that he is a highly educated man, who works in the medical field and knows how to urinate in a pot. The nurse laughs uncomfortably in turn 21 and the patient makes his implication more obvious in turn 22 by stating 'I'm used to all these things'. The nurses response strategy appears to save her face and support the reasoning for her explanation by asking whether the patient uses urination pots in the dental surgery, which he does not. She then provides a further reason in turn 25 by stating 'they're a new thing in the lab' and attempts to continue her instructions. The patient interrupts her in turn 26 and attempts and succeeds to move the conversation to a related, but different topic.

In the latter turns the patient makes a joke about his perceived incompetence as the nurse asks him to get on the scales. In turn 39 the patient informs the nurse that she did not press hard enough on the scales to activate them and utters 'I even know how to work the scales'. He says this with a smiling voice, which could have the effect of reducing the face threat of his joke, but the implicature is clear: he is an intelligent man who does not need to be patronised.

A power struggle seems to be constructed over recognition of professional identity in these turns between the nurse and the patient. The nurse may not feel as though she is patronising the patient, but the patient evidently perceives otherwise. In his interview he stated 'I explain that I used to be a dentist purely because I'm familiar with all the terms and things so umm I mean obviously the average patient is less clued up about medical matters'. Despite this power struggle between the nurse and the patient in the aforementioned turns the patient evaluated the nurse as 'very good and respectful', so despite this short period of perceived patronisation, it did not affect his overall evaluation of the nurse and the consultation as a whole.

In regards to typical features of patronsing talk, the nurse uses the collective plural pronoun 'we' in turns 17 and 25, and she uses what could be perceived as simple sentences and simple language in turn 19 (Ryan et al., 1995). However, the simple language could be a result of wanting to express clear instructions and there is not an overwhelmingly frequent usage of 'we', which Makoni and Grainger (2002) claim to result in patronising talk. The linguistic features do not define the discourse as patronising, and the nurse also does not use exaggerated intonation or pitch, which are non-verbal cues for infantilising or patronising talk (Nussbaum & Williams, 2001; Sachweh, 1998). Still, the patient's responses express that he feels patronised and it is in these responses that patronising behaviour is identified.

Overall, throughout this section I have shown that simply analysing linguistic features that are typically perceived to be potentially patronising is frought with problems. Patronising talk cannot just be defined by features or interpretations of others (Caporael, 1981), but needs to consider the patient's responses; both in the following turns and in their evaluations of the talk in general. My analysis was similar to that of Marsden & Holmes (2014) in that I looked at various potentially patronising features within their context and unearthed similar findings. The use of these features were more often than not understood by the patients as reflecting care and nurturing rather than patronisation (as reflected in the interviews). The view that these features may be superficially relation-oriented in order to complete the work routine could indeed be a function of these strategies, but their effect seems to be an overall positive one.

A further finding was that generally nurses used these potentially patronising features with both younger and older patients in my dataset. Obviously, my setting differs from that of previous research (Backhaus, 2009; Makoni & Grainger, 2002) that largely studied communication in carehomes, and these two settings could result in differing nurse attitudes towards older patients. The patients in my dataset could have been evaluated by the nurses as independent and therefore patronising talk may not have occurred in this setting. There have been no comparisons of nurse-patient communication with older and younger patients within a primary care setting to date and my analysis suggests that there is very little difference in transactional talk used with these two age groups. However, some differences in nurse behaviour were identified, for example, nurse 3 used more praise with older patients and nurse 8 used more collective pronouns – both common features of patronising talk. This could suggest different approaches by nurses when talking to older patients, but does not necessarily mean that they are using patronising language. As stated earlier, patronisation lies in the evaluations of the hearer.

7.5. Conclusion

The analysis of requests within these interactions has uncovered ways in which they work within this setting and has yielded interesting insights. Firstly, due to the bottom-up approach of the analysis, I revealed three different types of requests that seem to be typical of this setting. Similar to Mulholland (1994), I found differences in requests that require an immediate action or a future action and referred to these requests as procedural and opening requests and follow up requests respectively. The current literature on requests does not differentiate between the timing of the proposed action, but my research has discovered that this seems to have an effect on their form, and on if and how they are mitigated. Although all three request types were most commonly formed as imperatives, a feature that seems to be typical of healthcare settings (e.g. Coupland et al. 1988), follow-up requests were also commonly formed as hypothesis and obligation requests with a frequent use of grounders. This is unsurprising, as giving reasons and the use of modals could stress the need for the patient to complete the act away from the consultation.

The high frequency of bald on-record requests could be due to a number of factors. The prominence of imperatives, especially for opening requests, could be seen as constituting only a small, or even no imposition as the acts are benefitting the hearer. For example, requests such as 'take a seat' and 'come on in' would definitely not threaten the face of the patient but would fit into Leech's face enhancing acts (2014). Small imposition requests such as 'clench your fist' may go against the patient's negative face wants, but the patient will most likely know, due to the activity type of taking blood, that this action will make the process quicker and ultimately benefit them, although, as Coupland et al. (1988, p. 260) argue we should 'not assume the recipients share this perception'.

This chapter also outlined a typical phase structure of the communicative aspects of the blood-taking process, providing insight into this activity type and displaying that patients' schematic knowledge of the process sometimes renders vocal requests unnecessary (e.g. rolling up sleeves). Providing an outline for the typical processes involved in taking blood allowed me to study the practices of individual nurses as some used almost every phase in all of their consultations e.g. Nurse 8, whereas others barely used any, e.g. Nurse 7.

These individual styles did not only appear in the blood-taking process, but throughout the consultations as a whole. Nurses 7 and 2 appeared to focus largely on social talk and used fewer requests than other nurses. The evaluations of the patients of these two nurses were extremely positive and suggest that a more relational versus task-centred approach may improve patient satisfaction (as noted by Anderson, 2002) .

Finally, this chapter looked at the differences of requests aimed at younger vs. older patients due to potentially patronising features occurring in and around requests (Agledahl et al., 2011; Grainger, 2004). I looked at the use of specific discourse features in requests and whether the talk surrounding these features could be potentially perceived as patronising, similar to the methodology of Marsden and Holmes (2014). Throughout my analysis of these discourse features, I found few differences in how requests were uttered to older vs. younger patients and discovered little evidence of patronising talk. When these features were used, they seemed to

function instead to build rapport, for example, the use of terms of endearment by Nurse 2 (similar to the findings of Marsden and Holmes (2014)). These features were also not understood as patronising by the patients and I have argued that the hearer's perception cannot be ignored in defining what is or is not patronising talk. My findings could be specific to the setting of the GP surgery as previous research has tended to be carried out in care homes and geriatric hospitals (Backhaus, 2009; Makoni & Grainger, 2002), potentially causing the nurses to activate negative stereotypes of older patients that have reduced autonomy and lower functionality, resulting in accommodative speech. The nurses within the GP setting could have more positive stereotypes of older patients and therefore may not use as much patronising talk as in other healthcare settings.

CHAPTER 8

8. HUMOUR

8.1. Introduction

As reviewed in section 4.5, humour is often found to have positive effects on healthcare worker and patient interactions; for example, improving patient satisfaction (Fraley & Aron, 2004; Scholl, 2007). However, research focusing on humour within the clinical setting tends to lack primary data, to ignore patient perspectives and to want theoretical grounding (with the exception of Grainger (2004b), Ragan (1990) and Schöpf et al. (2017)).

As discussed in sections 4.5.1 and 4.5.2, there are two relevant bodies of literature pertaining to this chapter – linguistic and healthcare perspectives on humour. The frameworks of both Brown and Levinson (1987) and Leech (2014) note that humour and laughter can build rapport and are 'tools' used by interlocutors to engineer social relationships, perhaps to create social harmony, something that is also the business of politeness (see section 2.3). Beyond this, sociopragmatic researchers such as Norrick (1996), Boxer and Cortés-Conde (1997) and Haugh (2010) have examined the role of humour in everyday interactions through the application of conversation analysis and pragmatic theory, highlighting its relational effects.

This chapter aims to bridge the gap between these two fields of literature by qualitatively analysing how humour is used in nurse-patient interactions via the application of frameworks devised in linguistics for the analysis of humour and/or politeness-related phenomena.

The following questions will be addressed in their respective sections:
1. Who uses humour? (Section 8.2)

    The studies reported in Section 4.5.1. found that patients were reported to use more humour than nurses (Adamle & Ludwick, 2005), but that nurses introduce humour in the first instance (Warner, 1984). These studies ignored

specific variables that could have affected the amount of humour, whereas this section views patient age, gender and frequency of visits as potential factors in humour usage – hinting at individual styles of humour from both nurses and patients.

2. What forms of humour are most frequent? (Section 8.3)

    The nursing literature, essentially, provides a list of dos and don'ts (section 4.5.1), which includes forms of humour that should be avoided e.g. teasing and sarcasm. Despite these directives, nurses did use teases and sarcasm with positive effects and not just with patients with whom they had previous rapport (as stated in the literature (Hay, 2000)).

3. How is humour responded to? (Section 8.4)

    As seen in section 4.5, the nursing literature largely ignores responses to humour and the fact that humour is principally collaborative. Collaboration by the nurse as a recipient of humour is surprisingly small in the dataset of this study and nurses are typically strategically serious in their responses. Potential reasons for this are discussed in section 8.4.

8.2. Who Uses Humour?

In order to cast light on the nature of humour in nurse-patient interactions it is important to discover which interactant initiates humour and ascertain whether these initiations are typical of nurses and patients in general or whether they have individual styles. Within the healthcare literature patient usages of humour have widely been ignored and there has been a clear focus on nurse-initiated play. Previous literature also lacks primary data as studies were based on questionnaire data, interviews, surveys and diaries (Åstedt-Kurki & Isola, 2001; Granek-Catarivas et al., 2005; Haydon & Riet, 2014; Ridley et al., 2014). The few studies that have looked at the initiation of humour via the usage of primary data (in a hospital setting) suggest that patients initiate humour more than nurses (Adamle & Ludwick, 2005; Emerson, 1969), highlighting that patient roles in interaction should not be ignored. (These studies are discussed in further detail in section 4.5.1.) Finally, the medical literature has ignored a patient's main source of healthcare within the UK, the GP

clinic and very little is known of the intricacies of nurse-patient interaction within this setting.

The definition of play talk and humour attempts was described previously (section 5.7.2.2.) and has been adapted from Holmes and Hay's (1997) definition. Humour occurred in 94 out of the 100 recorded interactions. Within these 94 recordings there were 585 instances of humour in total. Patients initiated humour 360 times (61.5%) whereas nurses initiated 225 instances (38.5%). Evidently, patients initiate more humour than nurses. This finding is consistent with the findings of Adamle and Ludwick (2005) and Schöpf et al. (2017), who found that patients initiated 75.3% of humour in an Irish care setting. The results are somewhat expected as the nurse has a job to complete and their thoughts may have been on carrying out the task at hand in a professional and swift manner. Patients often introduced small talk and a play frame whilst the nurse was preoccupied doing tests, possibly due to the want to fill silences within the interaction. Norrick (1996, p. 20) states that filling uncomfortable silences is one of the main purposes of humour and I would expect this to be one of the reasons for more humour being introduced by the patients than the nurses. Patients have also been noted to use humour to signal discomfort (DuPre, 1998; Grainger, 2004b), display their identity (Åstedt-Kurki & Isola, 2001; DuPre, 1998) and to express frustration (Wender, 1996). I will discuss the possible reasons for the introduction of humour in my qualitative analysis below.

8.2.1. *Nurse Styles*

When looking at the average number of humour instances for each of the nurses separately, we can see that some nurses used a lot more humour than others.
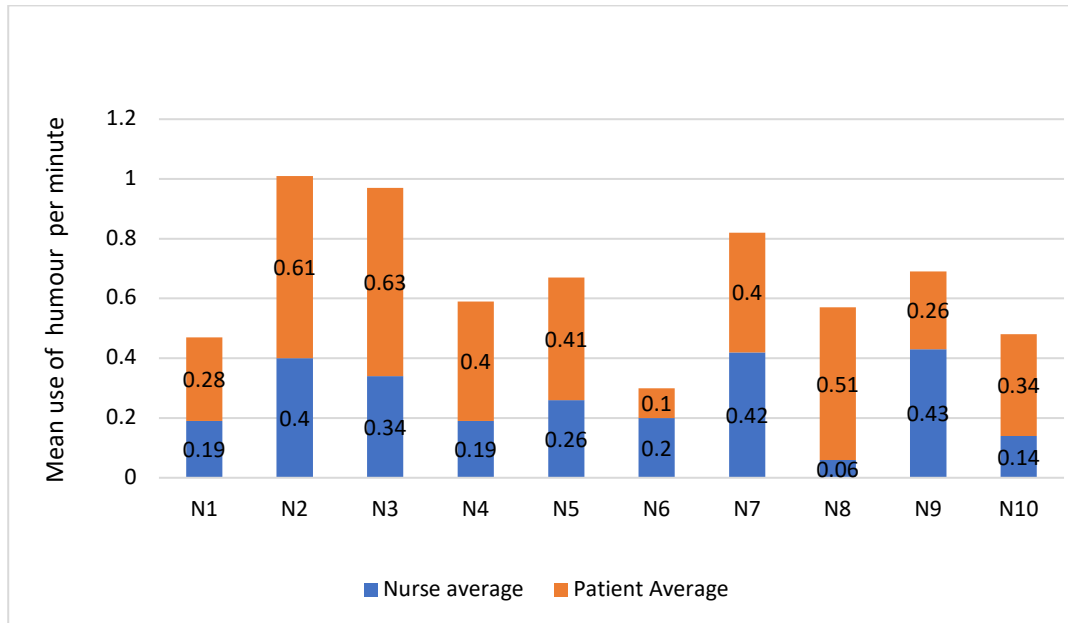
Figure 7: Comparison of nurse and patient mean use of humour per minute

Nurse 8 used less humour than the other nurses, and six of nurse 8's patients reported in the post-interaction interviews that the consultation was 'fine', 'ok' and 'good'. Although these are positive assessments, they are much less affirmative than the adjectives 'wonderful' and 'excellent' which nurse 7 received, who used the largest amount of humour. It was expected that patients would typically be positive in their post-interaction interviews, but the grading of adjectives show that a difference can still be established. Humour appears to create a positive impression on patients as reported by Wanzer et al. (2004), as the nurses that used the largest amount of humour also received the strongest compliments.

In order to analyse individual nurse styles it was important to see whether they used a consistent amount of humour with patients or if their amount of humour varied. The following figure shows box and whisker plots for each nurse.
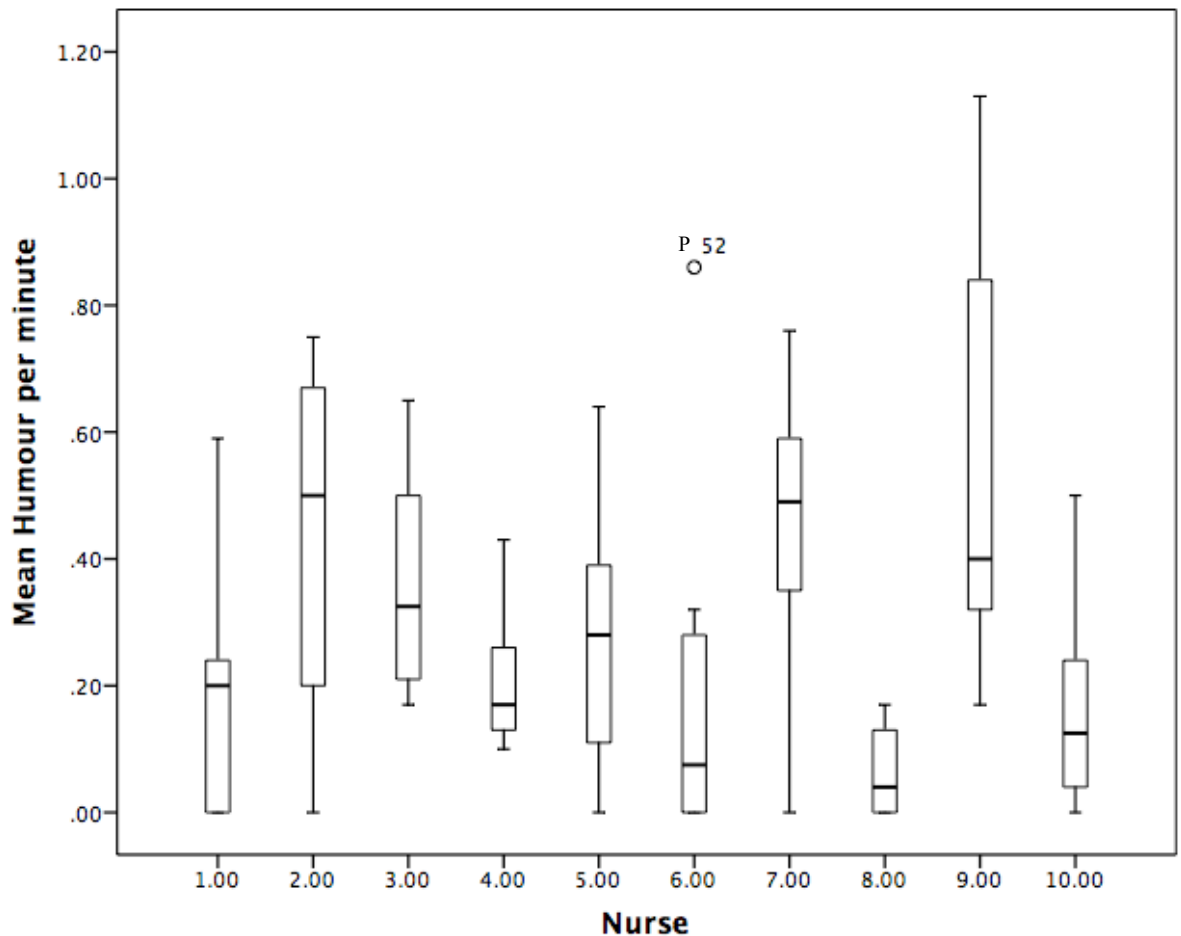
Figure 8: Box and whisker plot of nurses' mean humour attempts per minute for each of their 10 patients

Box and whisker plots show the variability of the data and, evidently, the mean use of humour per minute for each of the nurses varies. Some nurses use little humour (6 and 8) whereas nurses 7, 9 and 2 used a large amount of humour, whilst also showing larger variability. Despite there being some commonalities there are outlying figures in the chart. For example, nurse 6 typically used little to no humour in her interactions with patients, but with patient 52 an average of 0.86 humour attempts were made per minute. Patient initiation of humour and its effects on the amount of humour within the consultation cannot be disregarded as Gouldner's reciprocity norm would suggest that behaviour, such as humour, is matched (1960) and so I would expect similar amounts of humour use by the nurse and the patient in each interaction. The following chart shows transcripts with the largest amount of

humour for both nurses and patients intersected by the mean use of humour for all nurses and patients. A chart with each individual nurse and with each of their patient's mean humour attempts can be found in Appendix 6.
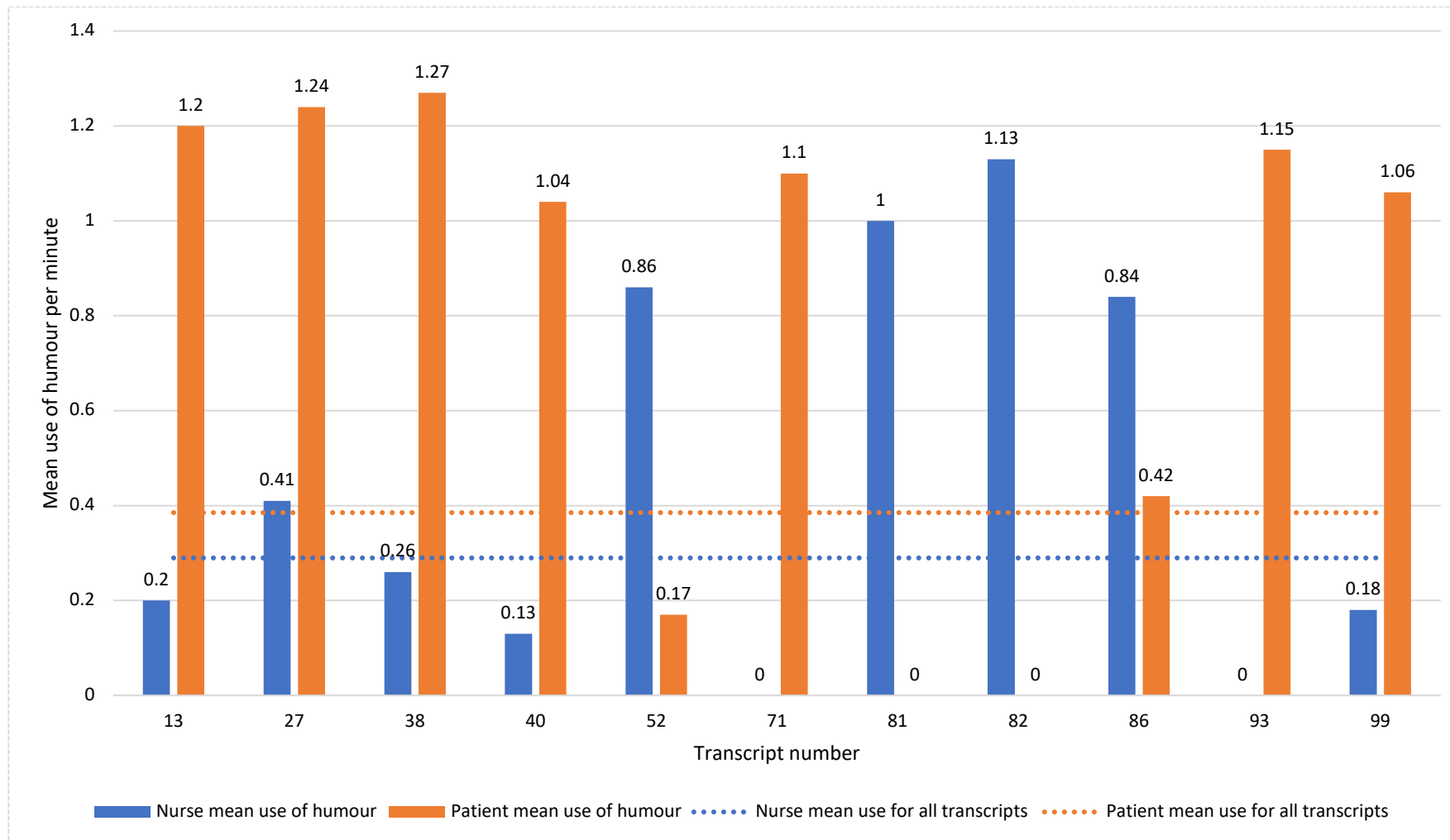
Figure 9: The highest nurse and patient mean humour attempts per minute intersected by overall mean humour use per minute

The amount of humour used by patients does not appear to have much of an effect on the amount of humour used by the nurse, as patients 13, 27, 38, 40, 71, 93 and 99 all used humour on average once per minute, but the respective nurse's attempts at humour were comparatively low. For example, Nurse 1 used only 0.2 uses of humour per minute with patient 13, while Nurse 8 used no humour whatsoever with patient 71 (the others can be seen in appendix 7). The opposite also seems to be the case as all four nurse averages that are over 0.8 humour attempts per minute have low or no patient attempts at humour. This could suggest that when one participant does not receive reciprocal humour from the hearer, they try harder to lighten the tone and use more humour than they usually would. It could also mean that the reciprocity norm does not seem to apply to humour in this context – this will be discussed in more detail in section 8.7.

8.2.2. *Patient Styles*

Similar to nurses having their own styles, it is unsurprising that patients would have their own humour styles as well, due to humour being a form of communication that displays the speaker's identity (Boxer & Cortés-Conde, 1997; Chinery, 2007; Wender, 1996). Males are typically believed to use more humour than female patients (Haydon & Riet, 2014) and age is not generally believed to have an effect on humour (Proyer et al., 2010; Sumners, 1990). However, no study has looked at these variables together. The following box and whisker plot displays age and gender variables for the mean amount of humour per minute for all 100 patients.
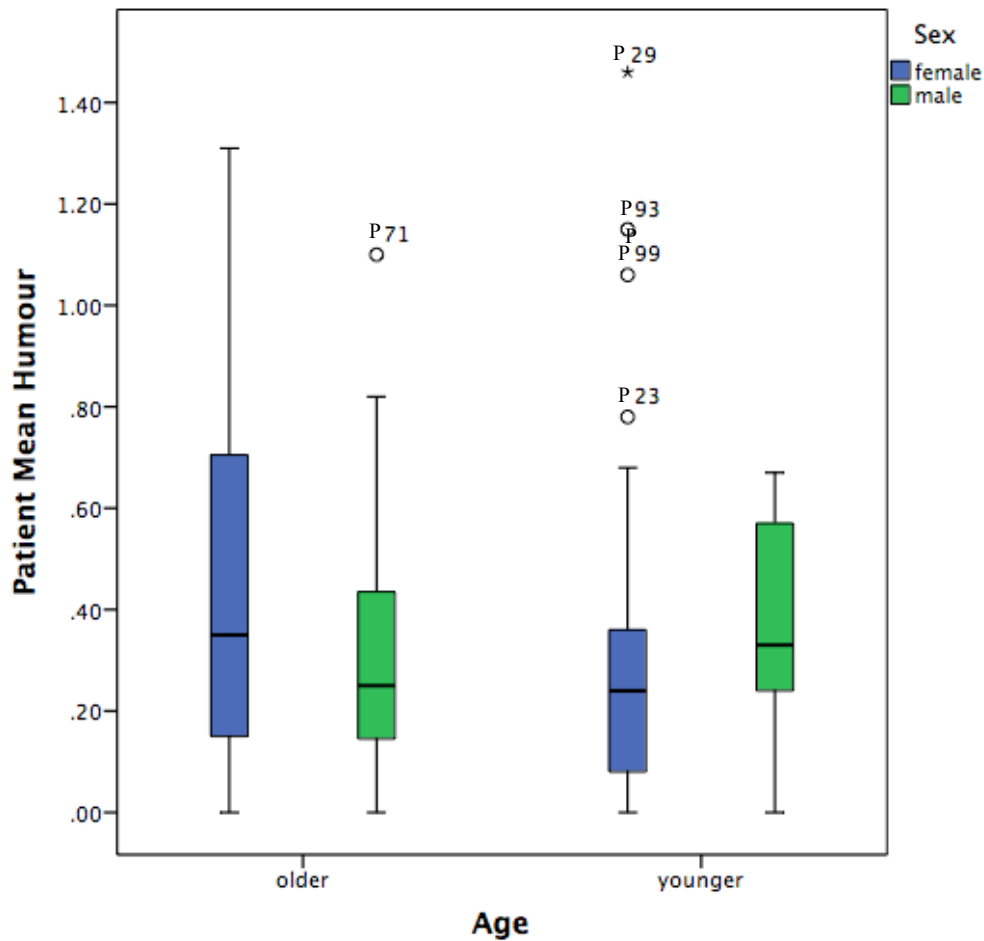
Figure 10: Box and whisker plots of patient mean humour per minute according to age and sex

Clearly, older female patients have larger variability and typically an increased usage of humour. Young female patients seem to use the least amount of humour, but this group also has a number of outliers in patients 23, 93, 99 and 29, who all use a large amount of self-denigration (defined in 4.1.2 and argued as a frequently employed form of humour by women (Boxer & Cortés-Conde, 1997). Despite the claims that men use more humour than women (4.1.1), it appears as though they are more consistent in their humour use, but do not, within this dataset, use more humour than older women.

This section has quantitatively outlined the use of humour by nurses and patients. It is evident that patients initiated more humour than nurses, similar to the findings of Adamle and Ludwick (2005) and Schöpf et al. (2017). Both nurses and patients

appeared to display individual styles of humour use, which is unsurprising as humour displays a speaker's identity (Wender, 1996). Nurse 7 used a consistently large amount of humour, especially in comparison to Nurse 8. It could be argued that nurse humour use has an effect on patient satisfaction as patients had a more positive response after Nurse 7's consultations. Finally, an interesting lack of reciprocity seemed to emerge in the consultations with a large amount of humour from one participant. This will be discussed in more detail in section 8.7.

8.3. When Does Humour Occur?

Previous research has suggested that nurses introduce the play frame initially within the interaction and then the patient can choose to continue it or not (Warner, 1984). I chose specifically to test this within the 100 interactions and see which participant would initiate a play frame in the first instance.

Table 30: The initial introduction of humour by interactants within a consultation

Frequency of visits	Initial usage of humour by Patient	Initial usage of humour by Nurse	No use of humour in Interaction
Never seen before	34 (53%)	13 (42%)	4 (80%)
Seen once or twice	19 (30%)	10 (32%)	1 (20%)
Frequent	11 (17%)	8 (26%)	0
Total	64	31	5

Contrary to previous research, it seems clear that the patients initiate the first instance of humour in the majority of consultations (FET p=0.01). The difference in findings could be due to a difference in setting and the fact that a number of the patients within the study had an on-going relationship with the nurses, meaning that they may have felt more comfortable to initiate a play frame. However, as can be seen in table 30, 30 of the patients who initiated humour first had met the nurse beforehand (seen once or twice or frequently), whereas 34 patients had never seen

the nurse before and still initiated humour in the interaction. This suggests that an on-going relationship may *not* have a large impact on whether the patient initiates humour. When looking at the nurses' data, despite lower numbers, it does appear that an on-going relationship may affect whether the nurse is the first to initiate humour with a patient as nurses initiated humour in 18 interactions with patients they had previously met (seen once or twice and frequently), in comparison to 13 initiations with patients they had never met before. This would need to be tested further with larger numbers, however.

Warner's (1984) study also claimed that humour occurred at the beginning of the interaction, but more recent literature suggests that healthcare workers needed 'some connection before there was freedom to introduce humour' (Dean & Gregory 2004, p. 141). The timing of humour was tested via the breakdown of each consultation into three sections. The first section, regarded as the beginning of the consultation, consists of the opening of the interaction e.g. greetings and 'how are you' requests that did not receive responses relating to the patient's health. The beginning of the consultation ends when the patient or nurse refers to the purpose of the consultation or starts to discuss health issues. The next section is categorised as the middle of the consultation and consists of all discourse related to health and the purpose of the consultation. It may also include small talk that occurs during this phase. Finally, the end of the consultation consists of the closing of the interaction, typically signalled by a discourse marker, e.g. 'right', that signifies the end of the medical process and involves patient and nurse partings. The data shows a clear indication of when humour tends to occur in nurse-patient consultations within a GP practice, as can be seen in Table 31.

Table 31: Number of initiations of humour according to stages of the consultation with average use per minute in brackets and range of phase length in square brackets

	Opening of Consultation	Transactional phase of Consultation	Closing of Consultation

Number of initiations by patient	32 (0.59) [2-287s]	294 (0.34) [54-1676s]	34 (0.44) [3-350s]
Number of initiations by nurse	21 (0.39) [2-287s]	172 (0.22) [54-1676s]	22 (0.28) [3-350s]
Total number of Occurrences	53 (0.98) [2-287s]	476 (0.56) [54-1676s]	56 (0.72) [3-350s]

Evidently, the largest count of humour occurred during the middle of the consultations in which discussion and completion of the medical procedure took place. However, looking at the average use of humour per minute shows that humour occurred more times on average at the beginning and end of consultations, however these were typically much shorter than the transactional phase of the interaction. This finding is similar to the findings of Warner's (1984) study, where humour tended to appear around the edges of conversation.

Overall, this section has provided a brief discussion of when humour occurs in nurse-patient interactions. It was discovered that patients tended to initiate the first use of humour in the consultation, contrary to existing research (Warner, 1984). Whether the patient had met the nurse before did not seem to have an effect on them initiating humour in the consultation. On average humour did occur at the fringes of the consultation, similar to the findings of Warner (1984), but this may have been due to the transactional phase typically being a longer stage and would need to be studied further.

8.4. What Forms of Humour are Most Frequent?

I categorised humour usages in my data using the forms of conversational humour outlined in section 4.6. The following table shows raw frequency counts and mean use per minute by the nurses and patients according to the forms of humour used.

Table 32: The forms of humour used by both nurses and patients and their frequencies

	Nurses (1-10)		Patients (1-100)	
Form of humour	Frequency	Mean use per minute	Frequency	Mean use per minute
Teasing	80	0.084	29	0.031
Sarcasm	3	0.003	19	0.02
Self-denigration	35	0.037	123	0.129
Joking about an absent other	21	0.022	35	0.022
Stock witticism	4	0.004	7	0.007
Language play	61	0.064	126	0.132
Other	21	0.022	21	0.022
Total	225	0.236	360	0.378

The most frequent form of humour for nurses was teasing, with an average of 0.084 uses per minute. This was followed by language play, such as hyperbole and punning with 0.064 uses per minute. Patients most commonly used language play, with 0.132 average uses per minute, and self-denigration, with 0.129 uses per minute. Language play was most commonly a form of relationship-building humour (Schöpf et al., 2017) that occurred during small talk. I chose to take a closer look at the use of teasing (section 8.5), particularly by nurses, due to its surprisingly large average use per minute, particularly as it 'runs along a continuum of bonding to nipping to biting' (Boxer & Cortés-Conde, 1997, p. 279). A second focal point was the use of self-denigration by the patients, which will be discussed in section 8.6.

A figure showing the forms of humour used by each of the nurses with their mean use per minute can be found in Appendix 7.

8.5. Teasing and Its Uses

Teasing was the most common form of humour used by nurses: 80 of 225 instances of nurse humour were teases (36%). Boxer and Cortés-Conde's (1997) definition of teasing was used to distinguish teases from other forms of humour. Teases were considered as verbal play that was directed towards the hearer and involved 'a figurative cutting down or diminishment of the hearer' (Haugh, 2010, p. 2107), or, in pragmatic terms, a face threat. To distinguish teases from insults, context had to be taken into consideration and contextual cues such as a smiling voice, laughter and intonation also aided the coding process.

The nursing literature sees teasing as a potential form of aggression and discourages the use of this form of humour due to its potential to 'bite' (Buxman, 2000). Despite this, the interviews suggested that teasing was evaluated as a positive behaviour and patients seemed to have more of an affinity with nurses that used this form of humour in their interactions. Rather than being used as a form of social control, as noted by Holmes (2000) and Hay (2000), it is evident in my data that teasing functions to build rapport and has the effect of making the patient feel more comfortable in the institutional setting.

8.5.1. *Teasing Used to Bond*

The following interaction occurred between an older female patient and a young male nurse. This was the first time that the pair had met one another.

Extract 57: Transcript 24

> 9. N: I know (.) have a seat (.) here y'are ((pulls chair out for P)) have you got a blood form^
> 10. P: ohhh I think I forgot it
> 11. N: O:::h eh (.) <u>you</u>'ll have to go <u>home</u> now and get it
> 12. P: You're joking
> 13. N: hhhhh

14. P: I didn't remember it

15. N: Don't worry (.) let me put your jacket on here

16. P: I remember now (.) it's in the it's in the letterbo-in the letter that I

17. N: You'll get fined next time

18. P: ((smiles)) will I? =how much?

19. N: hhh ohh we'll have to decide on that

20. P: hh

The nurse takes up a serious, frame in turn 9 as he requests the patient 'have a seat'
and offers the chair to her. He then directs the conversation towards its purpose –
blood extraction by asking if the patient has a blood form. She responds hesitantly
using hedges ('Ohhh I think I forgot it') and the nurse takes up a non-serious frame
by using a mock-impolite directive 'you'll have to go home now and get it', which
has the potential to threaten the patient's negative face. It is apparent that the nurse is
joking due to prosodic cues of elongated vowels and emphatic stress (Attardo et al.,
2003; Keltner et al., 2001). He also uses a paralinguistic cue of 'o:::h eh', which is
conventionally used to signal trouble. However, the patient, possibly due to hearing
difficulties, does not acknowledge the cues and responds apparently seriously, in
turn 12, with 'You're joking', expressing shock and disbelief. The nurse highlights
the insincere nature of his statement by laughing, but the patient continues to discuss
the issue more seriously in turns 14 and 16. Turn 16 is a grounder, functioning to
give an explanation for why the patient forgot her blood form and potentially
resulting in the effect of lessening the face threat to the nurse for the inconvenience.
The nurse takes up the jocular frame again in turn 17 by warning the patient that
she'll 'get fined next time'. This time the patient picks up on the cues and expands
on the verbal play, which results in laughter from both parties. The frame once again
switches to medical discourse and the matter at hand as the nurse focuses his
attention on the computer to find the patient's blood form.

This extract is interesting precisely because in line 12 it is apparent that the patient
has not picked up on the cues of playful teasing, which could have led to an
uncomfortable situation due to the potential negative face threat of the nurse's tease.
However, the nurse continues the play frame despite it not being acknowledged until
turn 18. The pair had never met before, contradicting the widespread assumption in

the literature that teasing only occurs in interactions where people are familiar with one another (Hay, 2000; Holmes, 2000), whilst also breaking the 'rules' (as discussed in section 4.5.1.) to using humour in a medical context. One could see the humour attempt made by the nurse to be emphasising his power (Meyer, 2000), but whilst this could be one reading, the patient certainly did not feel this way, stating that the consultation was 'excellent' and that she thought the nurse was 'kind' and 'lovely'. Given her evaluations of the interaction, it would seem as though this form of teasing and 'threatening' functioned to ease the atmosphere and build rapport between the two. This finding is congruous with the findings of Haugh and Bousfield (2012) and Haugh (2010), highlighting that although teasing can have the potential to 'bite' it can also have positive pay-offs. Even though the nurse's first attempts at humour were misinterpreted, and therefore not reciprocated, the tease seemed to have a positive effect on the interaction.

8.5.2. *Patients' Use of Teasing*

It's not just the nurses that use teases, but also patients, albeit less frequently. This is evidenced in Nurse 2's interaction with a young male patient. The patient comes in frequently for B12 injections and the two have clearly built a relationship.

Extract 58: Transcript 14

15. N: Ok lovely (N gets injection ready and P talks to researcher) Which arm are we doing today?
16. P: Oh just (.) do the one that's
17. N: Nearest (.) [Lucky left?]
18. P: [muffled] hhhh
19. N: hhhh
20. P: This one doesn't work the best of times (.) so ummm you may as well just do this one
21. N: Sorry I rudely interrupted you then whilst you were speaking
22. P: No that's (.) you could maybe get a job working at Audi then (smiling voice)

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23. N:  Who?

24. P:  you could maybe get a job working at Audi then (smiling voice)

25. N:  Oh yeah (.) Oh I love Audis (.) I love em

26. P:  (intakes breath) I'll sell you mine

27. N:  A posh company car

28. P:  ahhh

29. N:  Maybe I should go and work somewhere like that to get the nice car
        hhh

30. P:  No (.) you're too nice to work for Audi (.) but umm

31. N:  I can't get the lid off ((struggles with B12 vial))

32. P:  (coughs) we've been arguing left right and centre with them

33. N:  Wha- oh aye cause it's just (.)

34. P:  Keep trying to-
```

The patient uses a tease in turn 24 when the nurse interrupts his talk with the researcher by saying that she could get a job with Audi. To understand this tease one needs to hear the later interaction when the patient begins to complain about the company. He is suggesting that, similarly to the staff at Audi, the nurse is rude (albeit framed playfully). This tease has potential to be interpreted as impolite by criticising the nurse and her social behaviour. However, the attempt at humour was dependent upon the nurse recalling previous conversations as the patient's comment was building upon common ground (in turn 33 she remembers that he has been having issues with his car), without this previous knowledge the tease could (and was) interpreted as small talk with no humorous intent. This is an example of the continuity of care found in GP practices (Boddy, 1975), as the nurse and patient expand upon previous conversations and are able to recall facts about each other. This attempt at humour from the patient may have functioned to develop their relationship and suggests that these are not only medical encounters, but social calls too. Intriguingly, the humour attempt also had another purpose - it was used as a segue into troubles-talk about the patient's car and seemed to be a form of topic management by the patient.

8.5.3. *A Quantitative View*

A qualitative analysis can provide a detailed snapshot of what occurs in consultations, whereas a quantitative analysis can show trends. In this section I will look at teasing quantitatively and focus on potential influences on how much teasing was used in a consultation. The previous analyses have hinted at why teasing is used – largely to build rapport with the hearer, but this section will look at when teases are used and who uses them. I will take a closer look at the finding that nurses use teases with patients they have never met before and also distinguish whether particular nurses use teases more than others.

The first aspect to look at was the distribution of teases per nurse. I divided the number of teases used by each nurse by the number of seconds recorded to ascertain a mean number of teases per nurse per minute. The following table shows the results of this analysis.

Table 33: Nurse mean number of teases per minute for all 10 patients with mean time of consultation

Nurse and patient numbers	Mean time of consultations in minutes (Range)	Mean number of teases per minute (Range)
N1 (P1-10)	12:31 (06:30-23:40)	0.11 (0-4)
N2 (P11-20)	4:17 (2:00-7:30)	0.12 (0-2)
N3 (P21-30)	7:00 (4:35-14:05)	0.13 (0-3)
N4 (P31-40)	17:58 (7:05-29:00)	0.05 (0-2)
N5 (P41-50)	07:19 (04:20-12:30	0.04 (0-2)
N6 (P51-60)	8:00 (3:35-12:40)	0.08 (0-3)
N7 (P61-70)	8:24 (3:30-16:55)	0.15 (0-4)
N8 (P71-80)	10:10 (4:00-19:35)	0.05 (0-2)
N9 (P81-90)	7:39 (2:40-15:25)	0.09 (0-3)
N10 (P91-100)	11:50 (4:20-22:40)	0.08 (0-5)
Standard Deviation		0.037118429

Despite teasing being discouraged by the health literature (Buxman, 2000) all nurses in my sample used teasing to some extent. Nurses 1, 2, 3 and 7 all had a higher average of teases per minute (0.11-0.15) whereas its use by nurses 4, 5 and 8 was much less frequent (0.04-0.05). It is interesting to note that almost all of Nurse 8's uses of humour were teases and she only produced on average 0.06 instances of verbal play per minute. We can compare this to Nurse 9, who produced the largest amount of verbal play, 0.43 per minute, but used a rather low amount of teases (0.09). This could suggest that individual humour styles affect the ways in which nurses communicate with their patients. However, there could be other factors that influence the nurse's use of teasing, such as patient age, the relationship to the patient and sex of the patient, which are discussed below.

As the medical literature has suggested, teasing can be a form of patronising language used by nurses when talking to older patients (Marsden & Holmes, 2014). Due to this claim it is worth investigating whether the nurses more often oriented their teases to older patients rather than younger patients.

Throughout the 100 recordings the nurses used teases in 23 of the interactions with younger patients, compared to 25 of the consultations with older patients. Overall there were 37 teases with younger patients as opposed to 43 with older patients. It is apparent that there are no major differences in overall usage of teases by nurses and that age does not appear to make a difference to this form of humour. However, these numbers assume that all nurses are homogenous in their usage of teases. The following figure shows a breakdown of how each individual nurse used teases with younger as opposed to older patients.
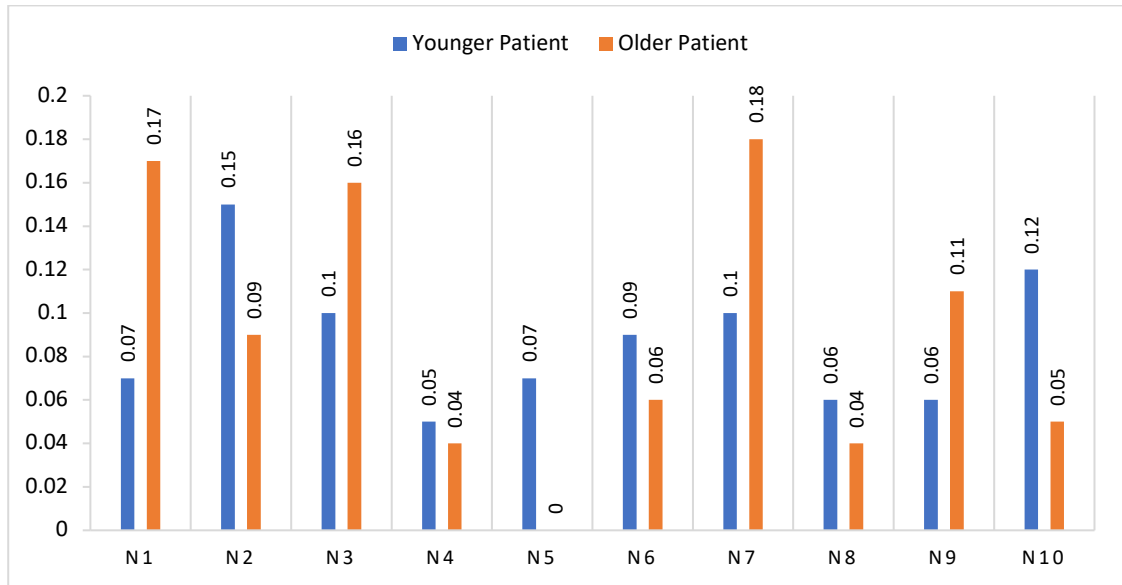
Figure 11: Mean teases per minute for each nurse according to patient age.

Nurse 5 was the only nurse who did not use any teases with older patients whatsoever. In contrast, Nurses 1, 3, 7 and 9 consistently use more teases with older patients, which could be argued as a potential sign that these nurses may treat older patients differently. However, there could be other factors that influence the amount of teasing used, for example, how well the patient and nurse know one another.

After the consultation, nurses were asked how many times they had met each patient: frequent patients, seen once or twice and never seen before. This is an important variable as researchers often claim that teasing and banter only occur in conversations between friends (Holmes, 2000, p.174; Leech 1983, p.144). As previously stated, this does not seem to be the case in my data, but I will now take a quantitative view to support this claim.

Table 34: Number and percentage of interactions in which teases by nurses occurred according to patient's frequency of visits

	Usage in interactions	**Percentage**
Never seen before	27 out of 51	52.90%
Seen once or twice	10 out of 30	33.33%

Frequent	11 out of 19	57.90%

The table shows the number of teases by the nurses in interactions with patients according to how many times they had seen the patient before. My data clearly shows that teasing *is* used between previously unacquainted nurses and patients as it occurred in just over half of these interactions. Not only this, but the proportion of teases used in never-seen-before interactions and frequent interactions nearly match. This finding also contrasts with the nursing literature as humour used in a situation with a lack of previous rapport and familiarity is deemed inappropriate (Bain, 1997; Dunn, 1993a; Erdman, 1994). As previously shown in my qualitative analysis, however, the teasing used was positively evaluated, which suggests that teasing can be appropriate in a medical encounter where nurses and patients do not know one another. It could also be suggested that teasing functions to engineer an appropriate context, one that is friendly and familiar for the patients. This would fit interactional pragmatics as not only is language shaped by context, but context can also be shaped by language.

Finally, Figure 12 represents the two variables of age and frequency of visits combined, to see whether there were any relevant trends.
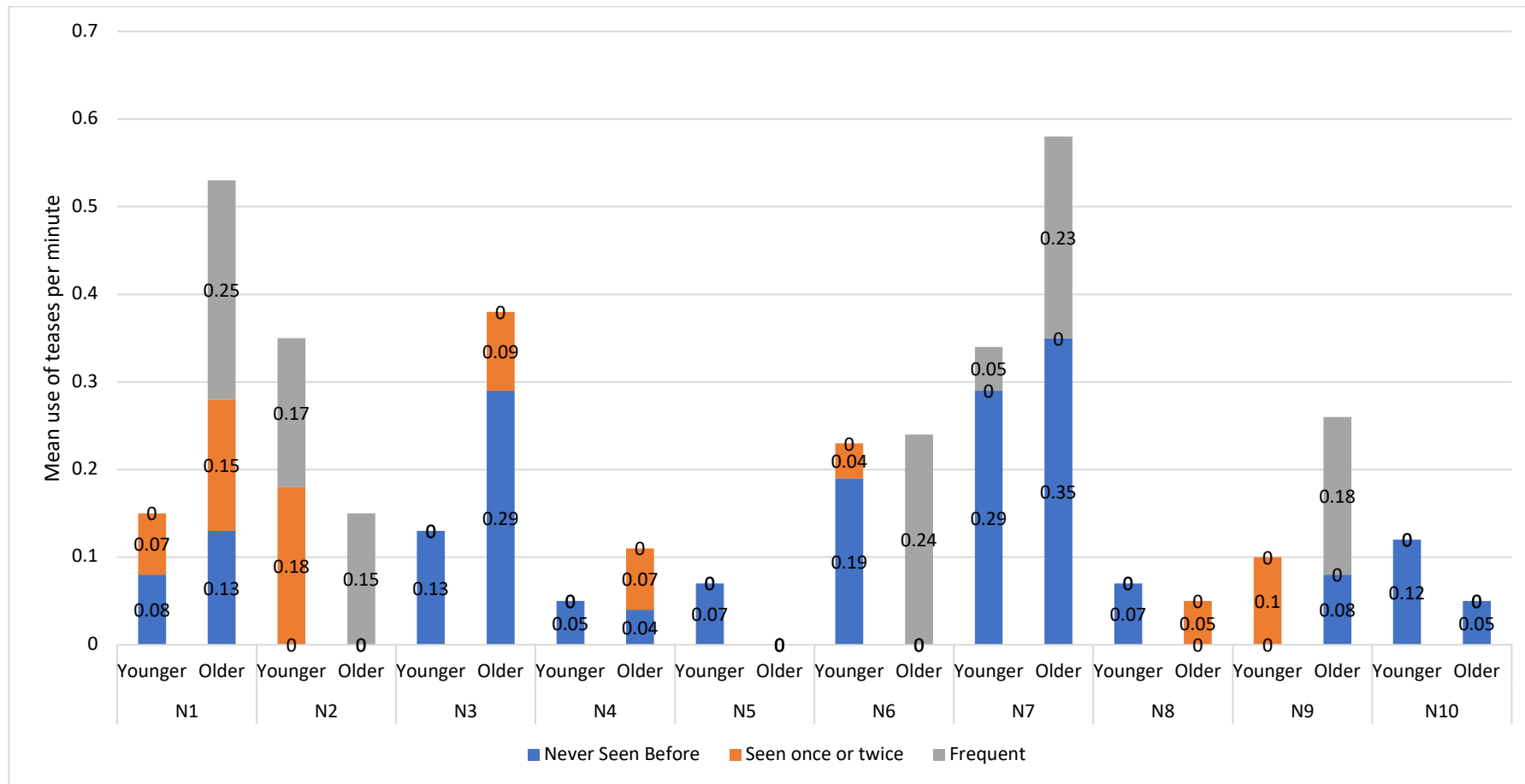
Figure 12: Mean use of teases by each nurse according to patient age and the frequency of visit

It is clear that Nurses 1, 7 and 3 use the largest amount of teasing with older patients, but interestingly, the largest use of teases by Nurses 3 and 7 were with patients that they had never met before. Could this suggest that teases in these situations are examples of exclusive teasing (teasing with an undercurrent of aggression, as in Grainger's 2004 study) or that these potentially biting utterances serve to help create an initial bond? As seen in extract 1, which is between nurse 3 and an older patient he had never seen before, the teasing seemed to function as a way to build rapport and create an initial bond, especially as it was used at the beginning of the interaction. Fraley and Aron (2004) claim that carefully framed humour in an initial encounter can be extremely positive and can help build rapport at such an important stage in the relationship. This is not to say that exclusive teasing does not occur in nurse-patient interactions, but is probably less likely to occur in GP interactions as they are generally one-to-one, whereas exclusive teasing was found to occur in hospital settings where more than one nurse was present (Grainger, 2004). The nurses in her study collaborated in patient teasing together and thereby created exclusivity, whereas in a GP setting this is extremely unlikely to occur and teasing's function would most likely be to bond rather than to isolate a participant.

Overall, teasing was found to be the most common form of humour by nurses despite its potential to 'bite' (Boxer & Cortés-Conde, 1997). Similar to the findings of Haugh and Bousfield (2012) it appeared as though teasing was used to build rapport and ease the atmosphere. This differs to the findings of Holmes (2000) and Hay (2000) who argue teasing in an institutional setting can be used as a form of control; it appears within this setting that it had positive pay-offs. The finding of a large amount of teasing was somewhat unexpected as the health literature discourages the use of teasing, due to potential misunderstandings (Buxman, 2000). Further to this, the linguistics and health literature (although somewhat dated) claims that teasing and banter only occur in conversations between friends (Holmes, 2000; Leech, 1983) and see it as inappropriate to use it with new patients (Bain, 1997; Dunn, 1993), whereas the data revealed that teasing and banter occurred in interactions with never-seen-before patients, and that it was positively evaluated. This suggests that teasing can be appropriate in a medical encounter, whether the participants are acquainted or not, but could also suggest that the nurses' use of teasing constructs a friendly and

familiar context for the patients, promoting comfort and potentially, patient satisfaction.

8.6. **Self-denigration and its Uses**

Just over a third of all humour attempts initiated by the patients were self-denigration (123 out of 360), similar to the findings of Åstedt-Kurki and Isola (2001) and Mallett and A'hern (1996). Self-denigrating humour consists of 'any play activity that makes the speaker the centre of the verbal playing' (Boxer & Cortés-Conde, 1997, p. 281), and these remarks are typically self-effacing. In order to identify these forms of humour within the data any self-effacing remarks were highlighted and coded as humour depending on the presence of any contextual cues e.g. smiling voice and laughter. Self-denigration is seen as a way to present a positive identity to the hearer, in that the speaker is able to make fun of themselves, make light of a situation and show a sense of humour (Norrick, 1996).

I will now look at two different consultations in which self-denigration occurred, analysing how it occurs in interaction and looking at potential functions of its use. The first interaction occurred between Nurse 1, a female diabetes specialist nurse, and a female patient of around 40. The two had a good rapport to begin with due to frequent diabetic reviews. There were six instances of patient-led self-denigration in the interaction, and I will analyse two of such.

Extract 59: Transcript 3

84. N: your full blood count (.) that was fine (.) just <u>one</u> of the levels was sli::ghtly low (.) but it doesn't really in its (.) just that on its own doesn't mean there's anything wrong really (.) umm (.) let's have a little look (.) long term sugar (.) that was forty (.) so within average to what it was in the past really=
85. P: =yeah and I'm still (.) to be perfectly honest (.) I'm not at my best (.) you know=
86. N: =yeah=

87. P: =when you're you're [working at your best and I'm not really]

88. N: [so overall you're keeping] your
    sugars down anyway (.) [overall]

89. P: [yeah well] I'm very lucky cause I need a slap on the wrist

90. N: hh we all do

91. P: hhh

The first extract is at the initial stages of the interaction when the nurse is giving the patient her blood results. In turn 85 the patient starts to talk negatively about herself and her health upkeep. The nurse shows she is listening by using back-channeling, 'yeah', and then returns to her positive blood results in turn 88. The patient continues to disparage herself by using the stock phrase of 'I need a slap on the wrist'. Here, the conversational turn displays to the nurse that the patient knows that she needs to improve her health and could potentially act to pre-empt any admonitions from the nurse herself. The nurse responds to the self-denigration by laughing and generalising the patient's statement by using the plural personal pronoun 'we'. This could be seen as a form of 'correcting' (Boddy, 1975) the self-denigration and saving the patient's face by not directly agreeing that she needs 'a slap on the wrist', but also could act as a form of inclusivity as she states that the fault is true of everybody, even herself, thereby heightening the patient's positive face.

The patient referenced the nurse's response to the first example of self-denigration discussed above in her post-consultation interview.

> I don't like people who are a bit efficacious, a bit umm cold and matter of fact 'you've put weight on and you need to lose it' I'm aware of the fact, my clothes are tight! Whereas (N's name) would say well we all have that to do, but it would help as it'll make your blood pressure come down a point and make you understand why it would help you rather than just say 'you're fat'…I feel as though they actually listen and then I feel in turn that I've got to try and do as well as I can, because they're helping.

Here the patient explicitly lists reasoning and generalisation to be factors that help build rapport with a health worker and make her more likely, as a patient, to carry out the requests that the nurse makes. This highlights the importance of the nurse's responses to self-denigrating humour. The following extract is from the same interaction.

Extract 60: Transcript 3

304.　N: that's if it's going to print (.) it takes its time
305.　P: not so bad if you send it to the right printer (.) I keep sending mine to the wrong one
306.　N: (hhh)
307.　P: wondering where it is (hhhh) in a warehouse somewhere (hhh)
308.　N: ((smiles)) right (.) I'll pop out and get this signed (.) won't be a minute

The second extract shows evidence of a personal anecdote that the patient uses to self-denigrate. Similar to the other extract the patient mocks herself. This turn could be multifunctional, acting to show that the patient has a sense of humour, to make light of the situation and share amusement with her interlocutor, thereby building rapport with the nurse. It is clear in the post-consultation interview that the patient thoroughly enjoys coming to see the nurse and respects her. For example, she stated:

'She's informative, but she's open to anything, you know any question and whatever I asked her, I feel as though I can trust her so much she will give me a true answer or she will give me an option (.) I like her (.) I don't ever feel (.) I think occasionally with some staff you can feel talked down to, but I don't ever feel like that.'

Overall, the patient uses a large amount of self-denigration in the interaction and most likely uses so much because she feels comfortable with the nurse. A probable function of self-denigration was to display a positive identity in showing that she could make light out of her health and printer-related issue. A further function of self-denigration may have been to save the patient's own face by pre-empting any

possible admonitions from the nurse. On the one hand, this could be linked to Åstedt-Kurki and Isola's function of helping to preserve dignity (2001), but they claim that this is used in 'difficult and oppressive situations' (p.123), which is clearly not the case in this context. Therefore, the usage works differently in this context to what was expected from the literature and provides another reason for patient-instigated humour in a healthcare context.

The second interaction occurred between an older female patient and an older female nurse (N4). The patient was asked to come in for a spirometry due to breathing problems. She had never met the nurse (whose sole role in the practice was to run the asthma clinic). The majority of humour instances in this interaction occur when the patient has issues breathing into the machine and the patient initiates a play frame of self-denigration which seems to have the effect of making light of the situation. I have selected three examples of this behaviour for analysis. I chose this interaction which involves self-denigration to show that it not only functions to make light of the speaker's difficulties, but can also function to cloak insecurities and anxieties, whilst also seeking support and encouragement in a 'polite' manner through the use of an off-record strategy.

The first example occurs when the patient has had difficulty breathing into the machine a number of times; it is important to note that a play frame has repeatedly been entered into in the interaction by both participants, but noticeably more from the patient.

Extract 61: Transcript 38

114.   P: yeah ((7.7s as N gets new tube out of cupboard)) do other people are they as bad as me? (hhh) or is it just me? ((laughing voice))
115.   N: sorry?
116.   P: is it just me that's awkward or [is most people (incomprehensible)]
117.   N: [no no no (.)] no (.) no (.) do you want me to give you a demo?

In this example the patient enters a play frame through laughing at herself and asking the nurse whether she is alone in finding the breathing test difficult. She makes a judgement about herself in describing herself as 'bad', and laughs. She then furthers her self-judgement by phrasing the question to only include herself and lightens the tone via using a laughing voice. This usage of self-denigration could act to make light of the patient's short-comings and portray her in a positive light by showing that she can laugh at herself. However, due to the interrogatives used it could also function to seek support from the nurse, due to feelings of self-consciousness about problems with the breathing machine. If this is the case, which seems likely, the patient is expressing her concerns and cloaking them with laughter and a jovial tone, thereby preserving her dignity and feelings of insecurity (Åstedt-Kurki & Isola, 2001). The nurse responds appropriately by repeatedly refuting the self-denigration in turn 117, attempting to ease the patient's concerns.

The following extract is much more straightforward in that the patient enters a play frame numerous times, the purpose of which is evidently to build rapport and show herself as self-effacing and 'approachable' (Boxer & Cortés-Conde, 1997, p. 281).

Extract 62: Transcript 38

131. N: but you need to keep it going
132. P: longer (.) I pulled the thing away didn't I? ((repeats breathing process and kicks feet in the air))
133. N: keep it going keep it going keep it going keep it going keep it going (.) that's good
134. P: ((coughs))
135. N: (hh)
136. P: ne ((coughs)) ne ((coughs)) nearly weeing meself (.) she's laughing her head off here ((looks at researcher, who is silently giggling))
137. N: (hhhhh)
138. P: everyone won't be as daft as me (.) love (.) don't worry
139. N: you're not daft at all love (.) you're fine
140. P: you've got to make light of things (.) haven't you?
141. N: you have (.) yes (.) so whenever you're ready?

142.	P: again?
143.	N: yeah
144.	P: oh you're just taking the mick now
145.	N: (h h h)
146.	P: you're having a laugh ((P pretends to hit N))
147.	N: I'm not really
148.	P: (hhh) ((breathes in again))
149.	N: keep going keep going keep going keep going keep going keep going
150.	P: ((coughs)) what d'ya think of that ((coughs)) they'll take me in and keep me in on that reading won't they?
151.	N: (hh) (.) right (.) if (.) it's not within a 5% so at the moment it's not ideal but we'll just try again (.) we need to try and get two within a 5% change

In this longer extract the patient once again initiates a play frame, not verbally, but via body language. She kicks her feet in the air whilst breathing to show the amount of effort she is putting into the exercise and slaps her feet to the floor when she has finished to express exhaustion. The nurse reads these gestures as play as she laughs in turn 135 and the patient furthers her play via exaggeration in stating that she is 'nearly weeing' herself. The patient's self-denigration begins in turn 138 as she refers to herself as 'daft', the nurse responds by rejecting the mockery as untrue (Haugh, 2010, p. 2108) and the patient portrays herself in a positive light via a justification by stating 'you've got to make light of things, haven't you?'.

The nurse attempts to enter a more serious frame by asking the patient to attempt breathing in the machine again in turn 141, but the patient immediately re-enters the play frame in turn 144, where the teasing acts as a cloak to her unwillingness. The patient even jokingly pretends to hit the nurse, which expresses the rapport they have built together in such a short time, as such behaviour could potentially be misinterpreted and seen as threatening. Physical attempts at humour are often seen as only occurring between intimates and are deemed risky behaviours (Baxter, 1992; Boxer & Cortés-Conde, 1997).

A final self-denigrating attempt at humour is made in turn 150, after the patient has breathed into the machine once more. She negatively evaluates her attempt through hyperbole and suggesting that she should be in hospital with such bad breathing. Once again, this self denigration could act as a way of portraying herself in a positive light and showing the nurse that she has a sense of humour, whilst also possibly hinting at her anxiety at the results. This interpretation has arisen from the interview data in which the patient states 'I was worried because I used to be a big smoker and I thought 'is it coming back to bite me in the bum?'.

The final extract comes from later in the consultation when the patient has received very positive results and been told her lung age is 31.

Extract 63: Transcript 38

273.   N: yeah (.) yeah (.) very good (.) but that (.) do you do a lot of exercise at the gym?
274.   P: I go (.) I normally go four to five times a week
275.   N: and do you do a lot of cardio?
276.   P: I don't do much cardio (.) because I haven't been able to
277.   N: no?
278.   P: but I still do 20 minutes
279.   N: right (.) right
280.   P: umm cardio (.) but I still do a lot of squats and umm
281.   N: you see (.) that's obviously helped you
282.   P: yeah (.) and I do 100 leg raises on the machine and a 100 squats so
283.   N: right
284.   P: I do a bit (.) I mean I'm still flabby (.) I'm (.) you know I'm 65 for christ's sake (.) I'm not going to look like I'm 16
285.   N: (h)
286.   P: you know I've still got the old bingo wings (.) but I'm [working on them (hhh)]
287.   N: [(hhhhhh)]
288.   P: but [I]
289.   N: [I] think you look fantastic (.) so (.)

> 290.   P: oh (.) thank you

Once again, the patient uses self-denigration, but for a different purpose. In turn 284 the patient states that she is 'flabby' whilst commenting on her age and in turn 286 she mentions having 'bingo wings'. The self-denigration here could be acting to show that she is 'not full of conceit' (Boxer & Cortés-Conde, 1997, p. 290), after what could be interpreted as boasting about how much exercise she does in previous turns. The nurse responds with laughter and disagreement of the patient's self-denigration in turn 289. Boxer and Cortés-Conde (1997) note that women will only joke about their bodies through self-denigration and the addressees will not further the tease, but simply laugh. This could suggest that this form of self-denigration is bound to both the gender of the participants and the context.

In summary, the two transcripts have provided a number of functions of patient-led self-denigration. The most obvious and widely used is to portray the speaker in a positive-light by showing a sense of humour, in doing this, rapport can be built as the hearer views the speaker as humorous and interesting. However, there are a number of other purposes that have been highlighted within this analysis; to save face, to express concerns, to seek comfort and to show that the speaker is not full of conceit. Self-denigration was the most common-form of patient-led humour and it is clear that it is being used indirectly to help the patients deal with the often-uncomfortable feelings that are attached to a nurse-consultation.

The transcripts also show that not only are the humorous utterances important, but the reactions to them are too; as Hay (2001, p.55) notes, a range of strategies can be used to support humour – laughter is just one. The nurses' responses act to help build rapport and trust. This is of particular note in the first extract, in which the nurse generalises the patient's self-denigration. The patient noted in the post-interaction interview that this response actually helps her trust the nurse and improve her own aftercare.

Furthermore, the contextual differences of the interactions in this section hint that a previously built rapport is not essential for this form of humour as the second patient had had no previous dealings with Nurse 4.

8.7. How is Humour Responded to?

Previous healthcare and linguistic research has largely ignored how participants respond to humour (section 4.5). As Hay (2001) states 'in order to fully account for the dynamics of conversational humor…it is imperative to reach a good understanding of the role of ALL participants' (emphasis added) and in particular how participants respond to humour as 'the audience plays a vital role in the construction of humorous discourse' (ibid.). The uptake of humour by a participant can result in collaborative humour, (i.e. a play frame, see 4.1.1.) potentially leading to the participants building solidarity with one another, or a rejection of a play frame, which could be interpreted as positively face threatening (Brown & Levinson, 1987). Despite the potential face-threat the data revealed that nurses would not always collaborate with patient attempts at humour – this section takes a closer look at why that might be.

8.7.1. *Collaboration and Reciprocity*

One kind of a response is collaboration, which involves the uptake of verbal play by the hearer. Coates states that 'conversational participants have to recognise that a play frame has been invoked and then have to choose to maintain it' (2007, p. 32). Collaboration can range from laughter to adding to the play frame, the key being that it shows a positive response to the humour attempt. The majority of humour attempts made by both patients and nurses had a positive response of laughter, agreement and reciprocity. As stated in section 2.3.4.2, reciprocity refers to social behaviour being matched by the hearer, or, as Culpeper states, with respect to negative behaviours, 'to retaliate in kind' (Culpeper, 2011a, p. 206). Therefore, reciprocity within the field of humour refers to the hearer furthering the play frame – a sub-division of

collaborative humour. This section takes a qualitative look at collaborative humour and the uptake of a play frame.

The following transcript is of an older female patient coming in for a blood test with a young female nurse (N2). The patient frequently visits this nurse.

Extract 64: Transcript 13

11.N: How's your neighbour?

12.P: Oh the new one?

13.N: The one that keeps coming round

14.P: Oh yeah she just keeps coming for a cup of tea she said just come for a cup of tea and I think (.) oh dear yes

15.N: She hides (.) Don't you hide sometimes?

16.P: Yes I know (.) we have a little thing in the door you know to look through

17.N: Sharp scratch

18.P: Yeah to look through (.) and if she's there I pretend I'm not

19.N: Awww

20.P: She's about twice my size (.) ten years younger but about twice my size (.) she fills the door (.) you know

21.N: (hh) How's your man friend?

22.P: Oh (.) oh (.) downstairs (hhh)

23.N: hhh

24.P: I got an easter egg off him hhh

25.N: hh What's his name?

26.P: I just know him as John and that (.) he sits on the seat ((smile fades)) (.) it's a shame really (.) he sits on the seat outside all day

27.N: On his own? Do you not sit with him?

28.P: No (.) Oh no no (.) of course not (.) I'm not encouraging him

29.N: Sit outside (.) He might just need a little (.) friend or something just to let off his problems or something maybe

30.P: He might do yes (.) no (.) I'm not going to try hhhh

31.N: Got enough of your own haven't you love

32.P: Yeah

The extract shows the nurse and patient collaboratively joking about absent others. After the patient brings up the subject of her living conditions, the nurse immediately asks 'How's your neighbour?' relating to a previous conversation. The pair then proceed to discuss the patient's neighbour, who is seen as more of a bother than a friend. The patient remarks about the neighbour's size and the fact that she comes around uninvited. These types of remarks could be functioning to build rapport between the nurse and the patient via joking about an absent other (Boxer & Cortés-Conde, 1997). The interactors are positing themselves in an 'in-group' by seeing the neighbour as different (ibid.). The nurse evidently finds it funny that the patient hides from her neighbour as she encourages her to tell the researcher about this fact (turn 15 'She hides (.) don't you hide sometimes?') The nurse and the patient are working together to co-construct the story – a phenomenon that would suggest that the two are close.

Joking about an absent other is furthered when the nurse asks about the patient's 'man friend' in turn 21. The pair laugh intermittently when discussing the male neighbour, but the talk takes a serious turn when the patient mentions that 'he sits on the seat outside all day' (turn 26), her smile fading. Although the pair don't actually discuss the man in much detail it is clear that he has been the topic of previous conversations and the two share in their laughter about this absent other.

One function of collaborative joking about an absent other is to bond the two interactants, and this seems to be the case here. The patient's and the nurse's language constructs the patient's neighbours in an out-group and functions to bond the pair via placing themselves in an in-group (Boxer & Cortés-Conde, 1997). The nurse and patient already have a close relationship and they discuss quite personal, non-medical aspects of the patient's life naturally, as if they were old friends.

Although collaborative humour can be used to build solidarity and rapport, the data shows that a play frame can be entered by both participants for other purposes. The following extracts show how a younger patient uses the collaborative play frame that was entered at the beginning of the interaction to express discomfort, which was a tactic noted by Coser (1959) as a way patients allay anxieties via verbal play.

Extract 65: Transcript 23

1.N: (First and second name of P) please (.) (First and second name of P) ((*No answer. P is in bathroom. P comes out of bathroom*)) (240)
2.N: Y'[alrigт]
3.P: [Sorry] ((P pulls worried face)) (hh[hhhh) ((nervous laughter))]
4.N: [You will be (hh]hh) (.) standing here waiting for <u>you </u>hhh
5.P: I love it when a plan comes together (hhh)
6.N: ((smiles)) Have you got your blood form at all?

This first extract displays the initiation of the play frame in the interaction. The patient initially laughs nervously due to taking up the nurse's time and the nurse responds with a mock-threat in turn 4 ('You will be'), signalling play using laughter. The patient collaborates with his humour attempt by suggesting that she had planned to keep him waiting. The two interactants had never met before, showing that collaborative humour can occur between participants on their first encounter (as previously shown in section 8.5).

Throughout the following turns the patient repeatedly re-enters the established play frame to show her discomfort at the process of blood extraction.

Extract 66: Transcript 23

41. N: =Just pump your wrist for me (.) nice and big (3) ((*P does not pump wrist*))
42. P: Maybe I should go chill out for a while hhhhhh

> 43. N: hhhh
>
> 44. P: I'm not usually that bad
>
> 45. N: I think I'm just getting everyone difficult today
>
> 46. P: No (.) you're just freaking me out hhhhhhh
>
> 47. N: hhh You've got one there I can feel

These turns show how the patient uses laughter and the switch from a serious frame to a play frame to express her discomfort. The extract starts in a serious medical frame as the nurse requests the patient pump her wrist, however, the patient enters a play frame by suggesting that she leave the consultation room, signalling play via a laugh. The patient's utterance hints at her discomfort/embarrassment, but due to the use of laughter, the implicature is minimised. In turn 45 the nurse teases the patient by implying that she is difficult. The patient denies his tease (Drew, 1987), but collaborates in the play by moving the blame to the nurse for having issues taking her blood ('you're freaking me out'). The colloquial vocabulary could be seen as a way to lessen the face threat along with the laughter that occurs immediately after, moving the threat from a serious frame to a play frame. The nurse does not seem to take offence as he laughs with the patient and immediately tries to reassure her by stating that he has found a vein. These turns could reflect how humour functions to cloak the patient's feelings of anxiety. The play could act to put her discomfort on record, but frame it humorously to make her 'complaints' ambiguous.

Despite the patient's use of humour to allay anxiety, the nurse collaborates with her in turn 45 with a tease. This could be because he has not picked up on her anxiety via the nature of the play frame. As seen in the following turns his collaboration with her humour ceases (in terms of continuing the play frame) and shorter responses of laughter are used to signal acknowledgement, but he consistently remains in a serious frame due to the task at hand – a phenomenon which will be referred to as 'strategic seriousness'.

8.7.2. *Strategic Seriousness*

A key feature of this data is the lack of uptake of a play frame due to potentially serious implications. This is somewhat similar to the findings of Jefferson (1984, p. 346), who found that a 'troubles-teller produces an utterance and then laughs, and the troubles-recipient does not laugh, but produces a recognizably serious response'. This lack of humour collaboration does not cause a face threat as the recipient is displaying sensitivity. My findings differ from those of Jefferson as the play was not limited to troubles-telling and included the functions of cloaked criticisms, displacing anxiety through humour and, largely, relationship protecting humour. I propose to refer to this particular form of rejection to a play frame as 'strategic seriousness', which can be defined as a lack of collaboration with a humour attempt due to the serious nature of the context or topic at hand. The following extract is an example of strategic seriousness being used by a nurse whilst he is trying to extract blood and calm the patient's nerves. Upon completing the task and diminishing the need to be serious, the nurse returns to a playful frame by collaborating with the patient's attempts at humour.

Extract 67: Transcript 23

36. N: Let's have a little look at your other arm
37. P: hhhhhh not satisfied with one (.) you're going for the other one as well (1) just thrown something on the floor there (2) as I say it's not usually this much of a problem (2)
38. N: Pump your wrist nice and big
39. P: It's going to be one of them days I can tell (whisper)
40. N: hh (5) There you are
48. P: You see (.) It's easy sometimes isn't it?
49. N: Can be=
50. P: =Can be (2) Best thing to do is look away (.) seen enough (.) don't want to know anymore
51. N: (1) Just release your hand for me (3) One down two to go
52. P: Thanks for that hhhh

> 53. N: Do you know what (.) I get the idea you don't like your bloods taken ((smiles))
>
> 54. P: Ummm it's=
>
> 55. N: =You're not likely to faint on me are you?
>
> 56. P: No (.) no (.) I don't like anybody else's (.) but I'm not too bad with my own (.) that's why I never do first aid at work (.) I don't want to know hhhhh
>
> 57. N: hhhh
>
> 58. P: I'd be having the first aid but umm nah it's the pain that's bad isn't it? (.) the pain bit freaks me out hhh
>
> 59. N: hhh
>
> 60. P: Like I say it's not normal problem
>
> 61. N: Well (.) you've just chose this day (.) to see me (.) to be a problem
>
> 62. P: Yeah (.) just to make it more fun and interesting for you (.) you'd get bored otherwise

The clearest example of strategic seriousness is in turns 37-40. In turn 37 the patient teases the nurse by suggesting that he is demanding too much from her and in a way, 'taking advantage'. This turn is classed as a tease due to the negative implication and the use of laughter to solidify her positioning in a play frame. In this extract the nurse does not collaborate with the humour attempt, but gives an on-record directive to the patient with no mitigation in order to be clear. Humour is created by using a stock witticism (Norrick, 1984) in turn 39 expressing her feelings of anxiety. Once again, the nurse does not continue the play frame, but does respond with laughter. There is a five second silence as the nurse focuses on hitting the vein and upon getting blood says 'there you are'. The patient enters the play frame once more in turn 52. There are two ways to read this turn:

1. The patient is displaying impoliteness through sarcasm, the use of a polite form 'thanks' hints at politeness whereas the prosody of the speech highlights that the opposite is in fact the case. The use of politeness formulae 'reminds hearers of the distance between favours that normally receive polite thanks and the disfavour in this instance' (Culpeper 2011, p. 28).

2. The patient is making a sarcastic joke which functions to lighten the mood.

I would argue that the utterance is a mixture of the two as jokes often portray the feelings of the speaker, but in a light-hearted manner. The nurse responds to the remark with a grin and flouts the maxim of quantity in stating 'I get the idea you don't like your bloods taken'. In this turn the nurse explicitly acknowledges that the patient has been expressing discomfort, but frames his acknowledgement within a play frame so as not to threaten the patient's face. Further evidence that collaborative humour is once again being maintained is in turn 61 when the nurse uses mock-impoliteness to suggest the patient was purposefully being difficult. The patient collaborates with his humour attempt through agreement. The tone of the consultation is much more relaxed at this stage, and the nurse has completed the procedure that was the focus of his attention.

The data is filled with examples of strategic seriousness from nurses, whether the nurse is focusing on a procedure or gleaning potentially serious information from a patient. This differs from the troubles-telling responses of Jefferson (1984) as the nurse's social role is to heal and aid patients so the nurse is showing sensitivity, but also carrying out their duty by responding seriously to these forms of humour. The following extract occurred between Nurse 1 and an older male patient. The two meet frequently for diabetic reviews and have built a relationship. The patient was identifiably upset and the nurse noted after the consultation that he was behaving differently than usual. In turn 41 the nurse asks him about his mood following several issues arising in his blood results.

Extract 68: Transcript 9

41. N: no (4.2s) so you're feeling low in mood at the moment
42. P: yeah
43. N: have you been to see the doctor?
44. P: you're joking aren't you? (hh)
45. N: why? ((whispered))
46. P: it's hard getting an appointment here

> 47. N: well you need to (.) be seen (.) you need to be seen really
>
> 48. P: I think it's easier to see the pope (.) than to see a doctor really (.) they tell you to phone up at eight o'clock and you don't
>
> 49. N: no
>
> 50. P: and it's all engaged (.) you know (.) so
>
> 51. N: who do you normally see?

In turn 44 the patient uses sarcasm to display his annoyance with the appointment system. The nurse could have misinterpreted his sarcasm as she thinks he does not want to see a doctor, rather than that he is finding it difficult to make an appointment. The patient clarifies in turn 46 and reverts back to play in 48, using exaggeration and a stock witticism ('it's easier to see the pope') which functions to express his frustration with making appointments to see a doctor. Although the patient does use verbal play, his humour constructs a complaint, critical of the healthcare system. The humour may have acted to soften the potential face threat of criticising the nurse's workplace and the healthcare system. Further to this, humour may have functioned to avoid any potential conflict that could have arisen from his criticisms (Mallett & A'hern, 1996).

The responses of the nurse are important to note as she does not collaborate with the patient. Instead, she takes what he says very seriously and attempts to make an appointment for the patient with a doctor in the following turns (not in extract). One may speculate that the nurse may have chosen not to take up the play frame due to potential health risks, and potential face-threat to the system of which she is a part. She assumes the role of the health provider rather than a collaborative partner in verbal play. Overall, this interaction highlights the sensitive nature of the consultation. Although the patient used verbal play, the implicature of his play was clear to the nurse and she did not respond with play, but with a serious attempt to rectify the issue that was pointed out by making him an appointment with the doctor.

A similar situation arises between Nurse 7 and an older female patient, once again a regular. A play frame was immediately entered into by the patient in turn 2, when she laughs at herself for stumbling into the room, but the nurse used strategic

seriousness, possibly in an attempt to discover whether this had larger health implications.

Extract 69: Transcript 67

---

1. N: Good morning

2. P: good morning (.) ohhh I'm feeling dizzy this morning [(hhh)]

3. N: [are you feeling]

   dizzy? Ohhh gosh (.) why's that?

4. P: I don't know

5. N: Not been drinking over the weekend have you?

6. P: It's the wind

7. N: Oh the wind (.) alright (.) we'll blame the wind ((dubious tone))

The nurse responds seriously, showing concern and attempting to discover the reason for the patient's dizziness. Her response is strategically serious as the patient's dizziness could hint at a potential health issue and the nurse takes what could have been a light-hearted comment from the patient to hold medical importance. However, in turn 5, after the patient brushes off the dizzy state to be unimportant, the nurse begins to tease the patient by suggesting that she has been drinking and could still be drunk and furthers this in turn 7 by hinting that the patient is using the wind as a scapegoat. This teasing could be interpreted as inappropriate and potentially offensive, but it did not appear to be understood as such by the patient. This extract highlights that nurses can switch very quickly from a serious frame to a playful frame. The nurse attempted to glean whether the patient's condition was chronic or an issue and when the patient showed little concern the nurse took up the play frame that the patient initiated and used humour to lighten the mood.

8.7.2.1. *Patient's Use of Strategic Seriousness*

Strategic seriousness, although typically used by nurses, was also used by patients. In the following example, a patient uses strategic seriousness after a humour attempt made by Nurse 6 to emphasise the effect her illness is having on her.

Extract 70: Transcript 52

> 6.P: Umm (.) I've had like (.) what feels like (.) possibly a virus (.) umm
>
> 7.N: ok ((whispered))
>
> 8.P: it's going round (.) I work next door
>
> 9.N: Oh right [h h]
>
> 10. P: [umm] and (name of boss) insisted that I come and see
>
>   somebody [so I (incomprehensible) h h h h=
>
> 11. N: [cause
>
>   he doesn't want it] h h h h
>
> 12. P: =h h well no (.) I was in floods of tears this morning=
>
> 13. N: =awww [you felt so]

Here the patient and the nurse have never met and the nurse attempts to introduce humour by joking about that patient's boss. The joke the nurse makes does not require her to know the absent other that she is making light of, but attempts to create a bond between the interactants. The patient laughs and agrees with the nurse 'well no', but then immediately gives a rather serious correction as to why her boss told her to go to the nurse. The patient (potentially) rejects humour collaboration to stress the degree of her illness. This extract shows that not only nurses use strategic seriousness, but also patients. Patients seem to use strategic seriousness to highlight the impact of their illness whereas nurses tend to use it to gain more information from a patient or in order to focus on the task at hand.

8.7.3. *Lack of Collaboration*

Despite the use of humour being deemed positive behaviour in a medical consultation (Coser, 1959; Dunn, 1993b; Ragan, 1990), it does not always result in nurse-patient bonding. The following extract highlights the importance of humour collaboration and suggests that simply laughing at attempts at humour is not always an adequate response to create a bond. The interaction involves N4, a female nurse, with a female patient in her late 60s. The two had never met before.

Extract 71: Transcript 40

> 7. N: so (.) how've you been with your breathing (.) you've come in just for a
>   COPD review I think (.) haven't you?
> 8. P: yeah
> 9. N: how've you been?
> 10. P: umm (.) ohh crikey (.) umm not too bad (.) I must admit this morning (.)
>   a very bad person (.) I've had <u>one</u> cigarette (.) only because I'm about to
>   jump off the edge of a cliff
> 11. N: right
> 12. P: and I'm sorry, because I've given up so (.)
> 13. N: right
> 14. P: but it was either that or hang someone
> 15. N: oh (.) hahaha
> 16. P: h h h h
> 17. N: it was probably your better option then h[hh]
> 18. P: [well I thought that] you
>   know (.) before he hangs me
> 19. N: hhhh
> 20. P: no (.) I had I actually had quite a bad night

In this extract the nurse and patient have just met and the nurse asks in turn 9 a typical 'how are you' enquiry. The patient responds with a real response (troubles talk (Jefferson, 1984), admonishing herself for having had a cigarette, she then uses exaggeration to make light of the situation and express a strong reason for her

regression. The nurse doesn't show any response to the verbal play and the patient in turn 12 expresses regret stating 'I'm sorry'. The lack of response by the nurse could be an attempt by her to signal to the patient that this is a serious matter (strategic seriousness). The patient once again uses exaggeration in an attempt to enter a play frame by stating that she was close to hanging someone reiterating that her relapse was not a light decision. This time, the nurse does respond with laughter and in turn 17 even furthers the play by excusing the patient's regression. The play frame ends abruptly when the patient switches the frame from play to serious with the use of the adverb 'actually' and, without exaggeration explains why she had a cigarette. This is another example of patient-led strategic seriousness as she rejects humour collaboration through the want to explain her relapse (despite introducing the humour in the first instance). Purely from this extract it would appear as though the two were building quite a good rapport by entering a play frame so quickly in the consultation and by collaborating together to create humour. However, the more humour that is used in this interaction, the more distance seems to be created, as in the following extracts:

Extract 72: Transcript 40

97. N: =yeah (.) right (.) if we just do another one if you don't mind?
98. P: she's trying to [kill me]
99. N: [sorry (hh)]
100.   P: I don't have to [do it myself she's going to do it for me]
101.   N: [not really (hhhh)]
102.   P: (hhhh)
103.   N: not really ((laughing voice))

In this extract the patient uses exaggeration to tease the nurse about trying to kill her, she uses humour here to display discomfort about having to breathe again into the machine, which she is clearly finding difficult. Both participants laugh to show that humour has been acknowledged, but instead of collaborating with the patient in banter (e.g. 'yes, I'm going to polish you off') the nurse apologises in turn 99, showing acknowledgement of threatening the patient's negative face wants. The nurse then reassures the patient by stating 'not really' twice, clearly sensing her

resistance. She does not expand on the play frame, but simply uses laughter as a response and refutes the playful assertion. The nurse here is using strategic seriousness to complete the task in a timely manner.

Extract 73: Transcript 40

122.   P: ((coughs)) yeah quite often in the middle of the night I'll wake up not being able to breathe
123.   N: oh no
124.   P: and then me husband has to start beating seven shades of whatsit out of me (.) not that he doesn't enjoy it (.) I have to (hh)
125.   N: yeah (.) yeah yeah (.) can you do a hard fast one now for me? really (.) so (.) deep breath in

In turn 122 the patient is discussing breathing issues at home in a serious frame (troubles talk (Jefferson, 1984)) and then starts to joke about her husband 'beating' her in turn 124. The nurse does not respond with laughter in this turn, possibly because of the potentially serious undertones of her joke. The nurse instead steers the conversation to the task at hand, possibly showing that she is more focused on getting the spirometry results. In the final extract another sensitive topic is brought into a play frame by the patient.

Extract 74: Transcript 40

145.   N: same again (.) deep breath in (.) hard and fast (.) but for as long as you can (.) and (.) you're due for a smear you know? Your smear is due
146.   P: umm:: I haven't got (.) a womb love
147.   N: but have you got a cervix?
148.   P: no (.) oh cer- uhhh
149.   N: because sometimes they can take your womb out but leave your cervix (.) so if you've got your cervix you need to have a smear
150.   P: well (.) it was (.) all I a total (.) everything gone
151.   N: oh right
152.   P: that was (.) a long long time ago
153.   N: oh ok

> 154.   P: (h) sorry (h[hhh)]
>
> 155.   N: [(hh) so there] (.) ok
>
> 156.   P: [((12.3s as P breaths in tube)]
>
> 157.   N: that's it (.) keep going keep going keep going keep going (.) very good (.) excellent]
>
> 158.   P: (hhhh) (.) oh:: I've had so many bits and bobs taken away from in there (.) it's unreal (hhhh) (.) I'm surprised there's anything left it's probably just one great big space
>
> 159.   N: (hhhhh)
>
> 160.   P: (hhh) I think they know me better at (hospital name) than I know meself

The nurse informs the patient that she is due for a smear test and the patient tells her that her womb has been removed. The patient hesitates and makes several false starts, potentially showing the uncomfortable topic and the patient's discomfort. She then sarcastically apologises to the nurse in turn 154 for not having a womb and laughs to show that she has entered a play frame. The nurse furthers the patient's verbal play and collaborates by putting herself in the patient's role and saying 'so there', acknowledging that she was wrong, whilst also saving her own face and maintaining a convivial atmosphere. After the breathing test the patient begins to laugh again and uses exaggeration to re-enter the play frame to which the nurse responds once again with laughter. The nurse may not have collaborated with this turn because of the sensitive topic.

These extracts may seem rather straightforward, but are provided as context for the patient's feelings that were brought up in the post-consultation interview. The patient complained that the nurse was 'rather focused on what she was doing rather than making me feel comfortable'. The patient felt that she was 'really trying hard' to make small talk and felt she was getting no response. She stated that she wanted to have a bit of a laugh and did not feel that the context allowed for it, commenting that it makes a 'heck of a lot of difference'. As one can see in the transcripts the nurse does respond to the patient's attempts at humour, but with rather minimal responses and she tends to move swiftly back to a serious frame rather than staying in playful frame for an extended period. For example, in turn 125 she responds with 'yeah yeah

yeah' to the patient's exaggerated troubles-talk and then requests her to blow in the tube. Norrick (1996) sees joking and laughter as an adjacency pair, but this interaction suggests that laughter is not always a sufficient response and potentially, more collaborative responses such as repetition, agreement or even disagreement (Drew, 1987) would be seen as more appropriate in this context. It was clear from the interview with the patient that she was attempting to build rapport through her use of humour and felt that the nurse did not reciprocate these attempts.

Overall, this section has shown the importance of humour responses and that simply analysing collaborative humour and play frames, such as the research of Ragan (1990), is not sufficient. Clearly, there are reasons behind a lack of humour collaboration and the setting and purpose of the consultation seems to be a large factor in this decision. Nurses tend to reject collaboration for professional purposes, such as inquiry into potentially serious matters or being focused on the task at hand, whereas patients seem to use strategic seriousness to support discrepancies in their health or reasons for attendance. A further finding is that a continual lack of humour collaboration can result in a negative patient evaluation of the consultation and a lack of rapport between healthcare worker and patient.

8.8. Conclusion

This chapter has looked at the use of humour in nurse-patient interactions in order to gain a better understanding of how this phenomenon works in this institutional setting. It was discovered that patients initiated more humour than nurses (consistent with the findings of Schöpf et al., 2017) and were also typically the first to initiate humour into the interaction overall, contrary to the research of Warner (1984).

Upon analysing the forms of humour used in the consultations, I found that nurses used a large amount of teasing whereas patients used more self-denigration. The analysis of nurses' teasing showed that it seemed to have positive effects on the consultation by providing a friendly atmosphere, despite the health literature viewing it as inappropriate (Buxman, 2000) due to its potential to 'bite'. A further finding was that teasing was used with new patients although both the health and linguistic literature predict that it should be used in established relationships (e.g. Leech 1983,

Bain, 1997). Teasing seemed to be used effectively by nurses and was evaluated positively by patients, suggesting that this form of humour is appropriate in this setting and can engineer a friendly consultation for patients.

The analysis of patient-led self-denigration discovered that this form of humour had a variety of functions, such as building rapport by showing a sense of humour, saving face, expressing concerns and seeking comfort. It was clear that self-denigration was used, particularly in and around physical procedures, to deal with the often uncomfortable feelings that are attached to health consultations. This section also highlighted the importance of the nurses' responses to self-denigration.

Finally, I took a closer look at the responses to humour by both nurses and patients. I noted that simply looking at successful and collaborative humour attempts is not sufficient (as that of Ragan 1990), and that analysing potentially 'confrontational encounters' (Sarangi & Slembrouck, 1997) can reveal institutional norms. An interesting lack of humour collaboration was noted in this chapter and I proposed the notion of 'strategic seriousness', which I defined as a lack of collaboration with a humour attempt due to the serious nature of the context or topic at hand. This differs from Jefferson's (1984) trouble's talk responses as strategic seriousness did not just occur around troubles talk, but also around cloaked criticisms and relationship protecting humour. A final, unsurprising, finding was that continual lack of humour collaboration seemed to result in negative patient feedback and a lack of rapport between participants.

CHAPTER 9

9. CONCLUSION

In this section I provide a summary of the findings of this study and address my research questions. Following from this, I discuss the implications of my research in both the healthcare and linguistic fields. Section 9.2 comments on theoretical implications, section 9.3 looks at potential practice and policy recommendations, whilst 9.4 notes methodological evaluations. The limitations of my study are noted in section 9.5, followed by suggestions for further research.

9.1. Conclusions on the Research Questions

The following sections bring together the findings and conclusions that were drawn for each of the research questions for my thesis. Each section uses the research question as a title and provides an answer in the following paragraphs.

9.1.1. *Is there a difference between how nurses talk to younger patients and older patients, and if so, what is the difference?*

One of the first aims of my research was to ascertain whether nurses within GP practices communicate with older and younger patients differently. The second aim was to determine if patronising talk occurs and how it works in this context. The following section discusses my findings regarding these two research questions.

Research has suggested that healthcare workers use 'patronising talk' when communicating with older patients (Backhaus, 2009; Herman & Williams, 2009b; Makoni & Grainger, 2002), which is generally perceived to be negative behaviour, but there has been no research on whether healthcare workers use this language with younger patients as well. My research suggests that within the GP surgery there was little evidence of nurses using patronising language with older or younger patients.

This finding is novel as no research has compared the language of nurses with younger and older patients, or looked at potentially patronising behaviour in GP surgeries. Specific features of patronising talk were analysed, similar to the methodology of Marsden and Holmes (2014), and despite these features being present in the data, they were typically not understood to be patronising (with one particular exception to this generalisation, see 7.4.6). Examples from my data show the use of first names, terms of endearment, praise and teasing with both younger and older patients, whilst also being positively evaluated in the post-consultation interviews. These linguistic devices appeared to be building solidarity and improving the nurse-patient relationship, similar to the findings of Marsden and Holmes (2014). However, I cannot deny the more cynical view that nurses may use these strategies to achieve their transactional goals more efficiently (Makoni & Grainger, 2002). Even if this is the case, the effect and patient evaluation of these features seems to be positive, rather than negative.

Although talk was not evaluated as being patronising by the patients, some discourse features used by nurses did occur more with older patients than with younger patients. For example, there was a larger number of imperatives used with the older patients, similar to the findings of Grainger (1993) and Herman and Williams (2009), which could be due to potential hearing issues as I found a number of repeated requests for older patients. However, there were also more examples of a flurry of requests, a feature noted by Mulholland (1994). Some nurses did use more potentially patronising features with older patients, such as Nurse 3, who used more praise with older patients, and Nurse 8, who used more collective pronouns in requests. This could suggest a slightly different approach to consultations with older patients, but cannot be simply classified as patronising talk - especially as the patients did not perceive it as such.

The patients evaluated the nurses' discourse very positively. The post-consultation interviews revealed very little negative feedback, although this could have been a methodological issue (see 9.4). The patients consistently discussed a friendly, positive attitude on part of the nurses that showed empathy and interest, but did not report feeling patronised or dehumanised.

Overall, this analysis has produced a number of important findings to both the healthcare and linguistic fields. I have found that nurses do not seem to use patronising language with older patients and that patient perceptions of patronising behaviour need to be taken into account. Previous literature has ignored the patient's perspective and has relied on the evaluations of others to deem whether an interaction is patronising (Atkinson & Sloan, 2017; Caporael, 1981; Caporael et al., 1983). Whilst this can provide a useful perspective, I argue that patronisation lies in the understandings of the hearer – a viewpoint that needs to be reflected more in the literature.

9.1.2. *Do nurses have individual interpersonal styles, and if so, how do they differ?*

My analysis of individual nurse styles yielded some interesting results. As previously stated, Nurses 3 and 8 showed differences to the other nurses in their usage of potentially patronising linguistic features. Moreover, Nurses 2 and 7 were found to differ from the other nurses in terms of the amount of relational talk involved in their interactions. These two nurses used fewer requests than the other nurses and Nurse 7 also used the largest amount of humour. They were both evaluated extremely positively by the patients, and I have argued that their focus on patients as individuals may have been the cause of these positive assessments. Nurse 2 also used terms of endearment with almost every patient and these usages appeared to be attempts to gain solidarity as the only interaction in which she did not use them was when she stated that the patient 'was a bit off'.

Despite politeness practices traditionally being understood as 'universal' (Brown and Levinson 1987) and nurses commonly being understood to use the same practices, especially when they work within a 'community of practice' ((Wenger, 1998) – a term used to identify groups with a common concern about a topic that share knowledge, ideas, styles and language with one another), the nurses within this study used different styles to communicate with their patients. Furthermore, the nurses who used a more relational approach were more highly evaluated. This suggests that

a more patient-centred approach has positive effects on patient satisfaction, as previously noted by Anderson (2002) and Charlton et al. (2008).

9.1.3. *How are the socially sensitive moments of talk managed? More specifically, how do openings and closings, requests and humour work?*

Finally, I also looked at the socially sensitive moments of talk in nurse-patient interactions within the GP practice, due to a lack of research within this setting, and found a number of features.

9.1.3.1. *Openings and Closings*

The consultation openings differed from doctor-patient openings (Robinson, 1998) as there were fewer phases. The nurses seemed to use summoning the patient to also secure the patient's identity. When using the patient's name the nurses generally used a title and their last name, but almost all patients in their post-consultation interviews reported preferring the use of their first names (similar to the findings of McKinstry, 1990; O'Connor et al., 2011). This could reflect nurses wanting to show respect to their patients by not assuming a closer relationship (Wood & Kroger, 1993), but their usage of last names could potentially do the opposite as one patient noted 'it makes you feel old if they use your last name' (Transcript 42).

Greetings and 'how are you structures' only appeared in around half of my data as compared to being used frequently by doctors in a similar setting, potentially suggesting a more task-centred approach. Further to this, there was a lack of reciprocity in features that were expected to be reciprocated due to being first pair parts of adjacency pairs (Schegloff & Sacks, 1973). A number of patients seemed to show a desire to 'get down to business', contradicting the view that healthcare

professionals are too task-centred. This is a finding that requires further study and could be particular to this setting.

The nurses also did not tend to introduce themselves despite the twitter campaign of #hellomynameis. The lack of nurse introductions could potentially create an imbalance in power and patients did appear to appreciate when a nurse introduced themselves (see section 6.2.3.1.) as the patients would often repeat the nurse's name and use it in the closing and transactional phases of the interaction, potentially to lessen social distance or show respect.

The closing sequences of nurse-patient interactions were collaborative and tended to involve a number of turns, similar to doctor-patient closings (West, 2006). I devised a figure that represented the typical closings of interactions and the cyclical nature of pre-closings, if they were not at first taken up by the hearer (see Figure 6).

The most frequent pre-closing was the mention of future contact (once again similar to doctor-patient closings (West, 2006), but the second most common pre-closing were indirect statements that have not been discussed in previous literature. Indirect statements were defined as a statement of finality that conveyed that both the procedure was complete and that the consultation was coming to an end. Examples of such were, 'there we go (.) all done' (Transcript 11) and 'so that's us' (Transcript 23). These pre-closings may have been used by nurses due to the procedures involved in nurse-patient interactions (such as taking blood) that are typically not performed by doctors in the GP surgery.

9.1.3.2. *Requests*

Upon analysing requests, similar to Mulholland (1994), I took a bottom-up approach by analysing requests in regard to the phases of interaction in which they occurred. This led me to discover three types of requests within this setting; opening requests, procedural requests and follow-up requests. The need to distinguish between these types of requests was due to their differences in form and when they were expected to be acted upon by the hearer. For example, follow-up requests were to be acted

away from the setting whereas opening requests and procedural requests were to be acted out immediately.

A majority of direct imperatives was used by nurses throughout all stages of the interaction, potentially due to small or non-existent impositions (as many requests benefitted the hearer), to reduce ambiguity and possibly to complete the consultation in a time-efficient manner. My findings did show that contrary to Marsden and Holmes (2014) not all direct imperatives were mitigated, especially in opening requests and procedural requests, but this may have been due to the function of these requests, as they typically benefitted the hearer. Follow-up requests were also commonly formed as hypothesis and obligation requests involving a large number of grounders, which can be explained by the role of the nurse to portray information and possibly the need to stress the importance of the act to the patient, who would enact the requestive action away from the consultation.

Finally, I proposed a communicative process of taking blood, providing a greater understanding of this activity type and the understandings of the participants within it. I demonstrated how patients seem to use schematic knowledge throughout this process (especially when preparing their arm) and how some nurses use very few of these stages and instead focus on relational work with the patients, suggesting a more patient-centred approach.

9.1.3.3. *Humour*

Both patients and nurses were found to use a large amount of humour in the interactions, however, patients tended to introduce it more than the nurses, similar to the findings of Adamle and Ludwick (2005) and Schöpf et al. (2017). Teasing was found to be the most common type of humour used by nurses, despite the literature warning that this may be inappropriate (Buxman, 2000). However, this form of humour seemed to be evaluated positively by the patients and appeared to build rapport and promote a comfortable environment, contrary to the arguments of Holmes (2000) and Hay (2000).

I noted the importance of studying non-collaborative humour and proposed the notion of strategic seriousness, in which nurses and patients reject humour collaboration due to a potentially serious context or topic. Patients would use cloaked criticisms, troubles-talk and humour to displace anxiety, which was not collaborated with by nurses due to a potentially serious message or procedure taking place. The nurses in these situations are not simply showing sensitivity (as suggested by Jefferson (1984)), but it is their role as a healthcare provider to respond seriously to potential health concerns presented by patients, whether in the form of humour, or not. In understanding the implications of these attempts at humour, the nurses are carrying out their role within the institution.

Overall, a number of typical features of nurse-patient interactions have been outlined that could provide a base for further research. Primary care is often the first call for patients and more research into the discourse of nurses within this setting needs to be done to uncover both positive and negative practices, whilst also gaining an understanding of this institutional discourse and how interaction works in this setting.

9.2. **Theoretical Implications**

Using the framework of Brown and Levinson (1987) combined with a number of frame theories allowed me to gain insight into the politeness practices of the nurses and the patients within these consultations. Despite the limitations of Brown and Levinson's framework, it was useful in analysing potential face threats, especially in this institutional setting where power and social distance play a large role. Using a third-wave approach allowed me to analyse the discourse in context, but also uncover social practices and norms within this setting. For example, I was able to combine Brown and Levinson's framework with contextual understandings in my requests analysis by also looking at occupational and institutional roles (Coupland et al., 1988). This allowed me to enhance the limited contextual variables of Brown and Levinson (power and distance) and focus on wider contextual factors that could have led to the mitigation of face threats.

Following from the analysis of openings, closings and humour a lack of reciprocity was noted. Greetings, 'how are you' questions and humour are typically understood to be adjacency pairs that have a preferred response. Throughout my data I found numerous examples of these features that lacked responses or received dispreferred responses and further studies could suggest that reciprocal responses to these turns may not be as frequent as commonly thought. This has theoretical implications as reciprocity is missing from almost all politeness frameworks (though briefly discussed by Spencer-Oatey 2008), but clearly needs to be more of a consideration in future research within pragmatics.

The analysis of requests led to a number of theoretical conclusions. As stated in section 4.4.1, Blum-Kulka et al.'s (1989) typology of requests was dismissed due to complications with its application to my data, such as no reference to 'let's' requests. This was most likely due to differences in methodology as their typology was built upon discourse completion tests, whereas my data involved audio-recordings. Aijmer's (1996) typology, with its grounding in empirical data, was applied with fewer issues to my data. This could suggest that its application may be superior, especially when analysing naturally occurring data. This is not to say that Aijmer's framework is infallible though, as I did add a few request forms to her typology, namely 'let's' requests, which differed from 'let me' requests, and clipped forms, which I did not wish to simply label as imperatives.

A further finding pertaining to request analysis was that the time frame of the proposed act could affect its form and mitigation (similar to the findings of Mulholland (1994)). This could be specific to healthcare or institutional contexts, but requests that involved immediate action as opposed to future action tended to be uttered differently, a feature that has not been widely considered in request analysis. Therefore, I proposed separating these forms of requests into procedural and follow-up requests. These requests not only had a different time frame of the proposed act, but tended to occur in different phases of the interaction, for example procedural requests occurred in the transactional phase and follow-up requests tended to appear during the closings of the consultation. I further separated the requests by another phase of the interaction – the opening, as these requests once again differed as they almost all benefitted the hearer (for example, 'take a seat' and 'come on in' were

coded into this category). I believe that distinguishing between these types of requests would allow researchers to gain further insight into how directives work, especially in institutional settings.

In regard to humour theory, previous research suggests that teasing occurs in established relationships (Leech, 1983); however, my findings showed that teasing within this setting was also used by nurses to build rapport with patients they had never met before. This finding furthers the research of Haugh (2011), who found that teasing was an important means of establishing a connection between strangers.

Finally, I proposed the notion of strategic seriousness to account for a lack of collaboration with a humour attempt due to the serious nature of the context or topic at hand. Nurses would used strategic seriousness to show sensitivity, gain more information from the patient, carry out their role as a healthcare worker or focus on the task at hand, whereas patients seemed to use it to highlight the impact of their illness. The use of strategic seriousness by nurses and patients also has theoretical implications as it differs from the lack of collaboration following troubles-telling (Jefferson, 1984). The humour used in my data was not just troubles-telling, but also included forms of cloaked criticisms, displacing anxiety through humour and relationship protecting humour. This could be a specific feature of nurse-patient interactions as the nurse is a provider of care and may not respond to humour attempts to support their professional identity.

9.3. Practice and Policy Recommendations

The analysis and post-consultation interviews, reflecting patient perceptions, revealed potential recommendations for practice and policy within this setting. Overall, patient satisfaction was high, suggesting that the current practices of the nurses within these two GP surgeries are received positively. However, some nurses were more positively evaluated than others. The nurses that appeared to provide more patient-centred communication by showing interest in the patients individually (for example, talking about their families, asking about their work, using humour and phatic communion (small talk)) garnered more positive feedback. This suggests that

similar to the findings of Anderson (2002); Charlton et al. (2008), patient-centred communication may improve patient satisfaction and nurses should apply a more patient-centred approach to their consultations.

Further to this finding and contrary to extant research (e.g. Buxman, 2000) teasing does not seem to be evaluated as inappropriate by patients and appears to help establish a comfortable environment and build rapport. Whilst nurses obviously have to be sensitive about the timing and framing of humour (Tanay et al. 2014), its use seems to have a positive effect and nurses could make more use of this 'untapped resource' (Åstedt-Kurki et al., 2001).

Whilst noting the importance of humour use, the importance of humour collaboration has also been noted. Although nurses and patients may use strategic seriousness effectively to focus on the task at hand or gain more information about potentially serious topics, continuously rejecting humour or a lack of reciprocation seems to have a negative effect on nurse-patient relationships. This could suggest that rejecting the patient's initiations of play repeatedly may threaten the patient's face and have a lasting effect on their interpretation of the consultation. Nurses evidently have to walk a fine line between interpreting potentially serious uses of humour and collaborating with play to help build a positive relationship and promote patient-centred communication.

In regard to the openings and closings of the consultations it is recommended that nurses introduce themselves, following the campaign of #hellomynameis. GP practices typically involve 'continuity of care' (Boddy, 1975, p. 1) and nurses should reflect this by introducing themselves to patients they have not met before. This study has shown that nurse introductions seem to have a positive effect on patients as they use the nurse's name throughout the consultation and in later meetings with the nurse. A nurse introduction may help to empower the patient and build trust between the interactants, as noted by Granger (2015).

The names of the patients were also highlighted as being important, as almost all of the patients interviewed stated that they preferred the use of their first name. Despite this, the nurses most commonly used the patient's last names, potentially to display

deference and respect. It is suggested that the nurses ask how the patients want to be referred to. This could create a more patient-centred approach.

Overall, this study has shown a number of ways in which patient-centred communication can be approached and the ways in which it is evaluated by the patients in my dataset. Obviously, not every person is the same and taking a more individual approach to communication appears to improve patient satisfaction.

9.4. **Methodological Evaluations**

Due to using a mixed-methods approach it is possible to draw conclusions on both of the methods used. The use of audio-recording interactions was, overall, very fruitful. Audio-recording was deemed to be less intrusive than video and enabled the researcher to completely focus on non-speech data (Walshe et al., 2012) via note taking. Obviously, not every smile or exhalation could have been noted, but an effort was made to make note of meaningful paralinguistic devices. This form of data collection was especially important for linguistic analysis within the institutional setting as it enabled the researcher to analyse language in use and gain a better understanding of social practices within this context (Jones, 2003; Locher & Schnurr, 2017).

Despite the overall positive reflections on this form of data collection, there were a few negatives. For example, there were a number of sections within recordings that were inaudible and could not be transcribed due to background noise or the participants speaking too softly. Also, participants would often interact with the researcher during periods of silence, which obviously would not have occurred if the researcher was not present.

The interviews provided interesting insights into the patients' perceptions of the interactions. Due to a semi-structured approach, patients were able to diverge from the questions in order to pursue ideas in more detail (Britten, 1995). This was useful as patients would pick up on specific points of the interaction to discuss, supplementing the audio-recordings. The interviews were typically positive, perhaps

due to patients believing a positive response was expected or not wanting to give a negative evaluation of the nurse. Research has shown respondents tend to give more positive and socially desirable responses in interviews (Presser & Stinson, 1998; Tourangeau & Smith, 1996). However, patients graded their positive assessments of nurses and, therefore differences in attitudes could be ascertained.

Overall, the triangulation of methods was successful, as patients' perceptions of language could be taken into account and the reliability of the researcher's interpretations was notably increased.

9.5. **Limitations and Contributions of This Study**

There are a number of limitations within this study. A number of these focus on the methodology. Taking notes of non-verbal aspects of communication was difficult and could have resulted in missed features. However, the use of video recording was deemed to be too pervasive in the setting and could have affected nurse and patient behaviours (as noted by Penner et al. (2007); Walshe et al. (2012)). Nurses and doctors in GP surgeries are commonly shadowed by trainees and patients may be more accustomed to another face in the room rather than being video-recorded.

Following from this, the presence of myself in the room could have altered behaviours, but the nurses became used to my presence and the need to complete their task more than likely resulted in them using typical behaviours. A similar situation most likely occurred with the patients, as Knox et al. (2002) found that 97% of patients post-recording admitted their behaviour had not been modified due to their need to raise health concerns.

The GP practices that agreed to be a part of the study could have better communication practices than other surgeries as a large number of surgeries refused to take part in the study. This could skew results and could explain the overall positive experiences of the patients.

Nurse age was not considered, but could have affected the use of patronising language as there could have been less of an age gap with older nurses and older patients, potentially resulting in a lack of patronising talk. However, this was considered too late in the data analysis process and some of the nurses had moved to other practices, meaning their age could not be identified.

The older patient age range could have been too large, once again, potentially skewing data as patients were considered older from 65 onwards. At age 65 the majority of people are mobile and have few health issues, compared to patients aged 80+, potentially resulting in different aging stereotypes being attributed to these patients (Hummert et al., 1994). Patients aged 80+ could be evaluated negatively due to their age, appearance and physical condition, whereas a younger 'older' patient, aged 65, could be perceived more positively (Giles & Gasoriek, 2011). This was considered, but would have largely increased the time it would have taken to collect the data. Research has also shown that even chronologically matched groups can widely vary in their needs, appearance and medical problems (Mann et al., 2001, p. 65).

Some of the initial patient interviews were quite vague and it took me a while to get used to the interview process and the best way to extract information from the patients. Over time this did improve, but did lead to a number of interviews being not as relevant as I had hoped.

Another issue with the interviews were that patients may have been overly positive about their interactions with the nurse. This may have been because they assumed I had an on-going relationship with the nurses and did not want to talk badly about them to me. This might have been remedied by the use of a questionnaire, but could have resulted in less targeted responses. The use of grading adjectives was also found to differentiate responses as some patients were much more positive than others, thereby creating a potential difference in evaluations.

Limitations regarding data analysis involve the subjective nature of humour and the possible misinterpretation of humour attempts. This was tackled by the use of a clear definition of humour attempts and outsider perspectives when I was unclear. A

similar situation arose with the identification of requests, especially off-record strategies.

Overall, there were a number of limitations with my study, but the majority of these limitations are known widely and were tackled in a number of ways. The methodology I used provided me with 100 audio-recorded interactions with nurses and patients in GP surgeries and 97 post-consultation interviews, providing a large corpus of data on which to draw my analyses. This is one of the largest data collections within the GP setting within recent years, especially in regard to nurse-patient interaction. (For example, Ohtaki et al. (2003) recorded 40 doctor-patient interactions; Seale et al. (2005) recorded 55 nurse consultations and Macdonald et al. (2013) recorded 35 nurse consultations.) It therefore provides needed insight into this area of communication.

The use of a mixed methods approach added to the need for empirical studies within healthcare contexts (Mullany, 2009), whilst also providing quantification to establish patterns and norms, a methodology typically ignored in pragmatic and applied linguistic analyses (Locher & Schnurr, 2017). Finally, the study also adds to the growing collection of politeness studies within workplace settings (Bargiela-Chiappini & Harris, 2006).

9.6. Further Research

Further research could be done in this area to gain further insight into nurse-patient relationships. Nurses could use patronising talk with an older group of patients, those that are negatively stereotyped (Hummert et al. 1996), due to immobility, the onset of dementia and general health deterioration making them more dependant. A study could compare the discourse of nurses with positively stereotyped older patients and negatively stereotyped older patients to ascertain whether there were differences in language use. I would suggest that such a study take a similar approach in methodology to mine as the patient interviews proved vital to hearer understandings of potential patronisation. The study could also gather data from focus groups on their understandings of patronising talk, who could also potentially listen to the

collected audio-data to provide further interpretations of whether a discourse involved patronising speech, similar to the study of Caporael (1981), but using this style of analysis in triangulation with other methods.

The data collected for this study could be analysed further by closer analysis of prosody as the current study only looked at prosody around potentially patronising features in requests and did not look at the whole interaction. This could provide greater insight into the nature of the medical visit and how intonation is used to get things done in this setting.

Data could be collected from specific nursing consultations, such as asthma reviews, to provide more comparability between consultations and the language used by both participants. This would enable the researcher to focus on specific stages of this style of consultation and potentially uncover more obvious differences in nurses' individual practices.

Finally, the notion of strategic seriousness that was introduced in this study could be researched further in other institutional settings. One could research whether this phenomenon also occurs in doctor-patient interactions, within a hospital setting or even further afield, for example, in schools or workplaces.

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APPENDICES

Appendix 1: Transcription Conventions

(.) A full stop inside brackets denotes a micro pause, a notable pause but of no significant length.

(0.2) A number inside brackets denotes a timed pause in seconds. This is a pause long enough to time and subsequently show in transcription.

^ When an upward arrow appears it means there is a rise in intonation

:: Colons represent elongated speech, a stretched sound

(h) When a bracketed 'h' appears it means that there was laughter within the talk

= The equal sign represents latched speech, a continuation of talk across turns with no break

[ ] Square brackets denote a point where overlapping speech occurs.

 (( )) double brackets denotes contextual information where no symbol of representation was available. For example, when the nurse gestures for the patient to sit down.

Appendix 2: Table showing information for each transcript in the corpus

Transcript Number	Nurse	Nurse Sex	Length of Consultation	Patient age	Frequency of visits	Patient sex	Purpose of visit
1	1	f	1420	younger	NSB	m	Diabetic Review
2	1	f	845	older	NSB	m	Diabetic Review
3	1	f	1085	younger	1 or 2	f	Diabetic Review
4	1	f	725	younger	1 or 2	m	Diabetic Review
5	1	f	925	younger	NSB	f	Vaccination
6	1	f	655	younger	1 or 2	f	Diabetic Review
7	1	f	505	older	NSB	m	Diabetic Review
8	1	f	510	older	Fre	f	Diabetic Review
9	1	f	450	older	Fre	m	Diabetic Review
10	1	f	390	older	1 or 2	f	Diabetic Review
11	2	f	180	younger	NSB	m	Bloods
12	2	f	450	older	1 or 2	f	Bloods
13	2	f	300	older	fre	f	Bloods
14	2	f	360	younger	fre	m	B-12
15	2	f	180	younger	1 or 2	m	Bloods
16	2	f	320	older	fre	f	Bloods
17	2	f	120	older	1 or 2	f	Bloods
18	2	f	160	older	fre	f	Blood Pressure
19	2	f	180	younger	1 or 2	m	Bloods
20	2	f	320	younger	1 or 2	m	Bloods
21	3	m	360	older	1 or 2	f	Bloods
22	3	m	350	younger	NSB	m	B-12
23	3	m	845	younger	NSB	f	Bloods
24	3	m	340	older	NSB	f	Bloods
25	3	m	390	older	fre	m	Bloods

26	3	m	500	younger	1 or 2	f	Bloods
27	3	m	290	older	1 or 2	f	Bloods
28	3	m	480	older	NSB	m	Bloods
29	3	m	370	younger	NSB	f	Bloods
30	3	m	275	younger	NSB	m	Bloods
31	4	f	1680	older	NSB	m	Asthma Review or test
32	4	f	1720	younger	NSB	f	Asthma Review or test
33	4	f	425	younger	NSB	f	Asthma Review or test
34	4	f	840	younger	NSB	f	Asthma Review or test
35	4	f	1740	younger	NSB	m	Asthma Review or test
36	4	f	950	older	NSB	m	Asthma Review or test
37	4	f	700	younger	NSB	f	Asthma Review or test
38	4	f	940	older	NSB	f	Asthma Review or test
39	4	f	870	older	1 or 2	f	Asthma Review or test
40	4	f	915	older	NSB	f	Asthma Review or test
41	5	f	260	older	fre	m	B-12
42	5	f	540	older	NSB	f	Wound dressing
43	5	f	330	younger	NSB	f	B-12
44	5	f	390	older	1 or 2	f	B-12
45	5	f	600	younger	NSB	m	Aches and pains
46	5	f	750	younger	NSB	f	Contraception
47	5	f	310	older	1 or 2	f	B-12
48	5	f	330	older	1 or 2	m	B-12
49	5	f	375	younger	NSB	f	Aches and pains

50	5	f	510	younger	NSB	m	Aches and pains
51	6	f	405	younger	1 or 2	f	Contraception
52	6	f	350	younger	NSB	f	Cold
53	6	f	645	older	1 or 2	f	Cold
54	6	f	475	older	NSB	f	Aches and pains
55	6	f	215	younger	1 or 2	f	Aches and pains
56	6	f	290	younger	NSB	f	Cold
57	6	f	730	younger	1 or 2	f	Aches and pains
58	6	f	525	older	NSB	m	Aches and pains
59	6	f	405	older	NSB	f	Aches and pains
60	6	f	760	older	fre	m	Aches and pains
61	7	f	510	older	NSB	m	Wound dressing
62	7	f	210	younger	NSB	m	Aches and pains
63	7	f	520	younger	fre	m	Bloods
64	7	f	210	younger	NSB	f	Vaccination
65	7	f	350	older	1 or 2	f	Wound dressing
66	7	f	1015	older	fre	m	Diabetic Review
67	7	f	470	older	fre	f	B-12
68	7	f	195	younger	fre	f	Aches and pains
69	7	f	615	younger	fre	f	Bloods
70	7	f	950	older	fre	f	Wound dressing
71	8	f	820	older	1 or 2	m	Bloods
72	8	f	460	younger	1 or 2	m	Bloods
73	8	f	730	younger	NSB	m	Bloods
74	8	f	720	younger	NSB	m	Bloods
75	8	f	350	younger	NSB	m	Bloods
76	8	f	705	younger	NSB	f	Bloods
77	8	f	1175	older	1 or 2	m	Bloods

78	8	f	420	older	1 or 2	f	Bloods
79	8	f	240	older	NSB	f	Bloods
80	8	f	480	older	1 or 2	m	Bloods
81	9	f	290	younger	NSB	f	Bloods
82	9	f	160	older	fre	f	B-12
83	9	f	580	older	1 or 2	f	Bloods
84	9	f	925	older	fre	m	Bloods
85	9	f	360	younger	fre	m	Bloods
86	9	f	285	older	fre	f	Bloods
87	9	f	495	younger	1 or 2	f	Bloods
88	9	f	720	older	NSB	m	Bloods
89	9	f	380	younger	1 or 2	f	Bloods
90	9	f	395	younger	1 or 2	m	ECG
91	10	f	1005	older	NSB	f	Diabetic Review
92	10	f	960	older	NSB	f	Asthma Review or test
93	10	f	260	younger	NSB	f	Vaccination
94	10	f	520	younger	NSB	m	Blood Pressure
95	10	f	265	older	NSB	f	Bloods
96	10	f	500	younger	NSB	f	Bloods
97	10	f	1360	older	NSB	m	Diabetic Review
98	10	f	720	younger	NSB	f	Bloods
99	10	f	340	younger	NSB	f	Vaccination
100	10	f	1170	older	NSB	f	Diabetic Review

Appendix 3: A full transcript

(Summons missed as R was in room before patient was called))

N: hiya

P: hi

N: Do you have a blood form? ((P does not respond to question))

P: I'm not very good at this (.) I don't like needles so=

N: =awww=

P: =bear with me ((P sits down))

N: let me have a little look at your arm ((N takes P's arm))

P: you'll probably never get veins (.) not very easily ((intake of breath as N looks at arm))

N: you might have one there that we can see (1.3s)

P: (h)

N: no actually (.) your veins aren't too bad ((N lets go of Ps arm))

P: aren't they?

N: is this:::: (.) is it a diabetic check (.) we're doing (.) or not? ((N looks at P))

P: I think she's ticked a few things

N: mm (4.2s) whose asked you to have bloods done? ((N starts looking on computer))

P: doctor::: (.) is it (.) (last name) (last name) (1.1s) I came in a couple of weeks ago because I was having really bad wind and diarrhoea

N: mhmm ((still looking at computer))

P: and she gave me a tablet (.) but I'm still [(.) so she's]

N: [yeah (.) still there]

P: yeah (.) it's uhh (.) I was thinking it was IBS because me daughter has been diagnosed with it and we've always been known for having dodgy tummies (.) so

N: yeah

P: so I think he's

N: (incomprehensible) ((N reads form on computer))

P: probably testing me for everything ((smiling voice))(hh)

N: (hhhh) right

P: we'll keep this one quiet and out the doctors (hhh)

N: (hh) (4.5s) ((N starts to prepare the needle))

P: how long is it till the bloods come back because I've got to (.) give make another appointment you see

N: umm (.) it's probably going to be about Monday (.) umm

P: oh right (.) that's fine so it's

N: when they're back

P: yeah (.) so if I make one for later in the week

N: yeah

P: it'll be fine (.) yeah

N: that's fine (.) did she tell you to make an appointment

P: yeah (.) she said because we need to discuss the bloods and also some tablets that she's given me

N: yeah (.) see if they (.) need changing or anything ((stops preparing needle and sits back down))

P: I'd like smaller ones (.) I can't take tablets ((laughing voice)) (hh) I'm terrible (.) I'm a walking nightmare aren't I?

N: (hhh) don't come to me again

P: ok (.) I won't (.) I'll try not to

N: (hhh)

P: (hhh) or if you see my name on your list (.) I'm not seeing her

N: I will (.) I'll just tell them

P: <u>don't</u> want to see her again (hhhh) (.) [nightmare]

N: [or a big sticker at the end]

P: <u>nightmare</u> (hhh)

N: right (8.4s) ((N prepares desk)) ok (4.4s) is it nice outside?

P: it's gorgeous

N: is it? (1.6s) wish I was out there (.) horrible yesterday wasn't it?

P: it was alright at first (.) but then it chucked it down (.) didn't it^ and all really (.) yuck

N: can I have a look at this arm first? (1.7s) ((N takes Ps arm))

P: umm (.) I know that they had given rain (.) but (.) I only expected you know a light shower (.) so I didn't go prepared so I had to get a taxi home from work (0.4s) cause I got soaked (hhh)

N: (hh) (.) it's alright (0.8s) just pump your wrist a bit for me (4.0s) ((P starts pumping wrist)) just try and relax (.) I know it's easy for me to say (3.3s) ok (.) just a little sharp scratch (.) it'll be ((N inserts needle)) (.) ok? ((looks up at P))

P: yeah (4.0s) I dread the day I need an operation because that will like leave her in the corner and that ((smiling voice))

N: awww

P: (hhhh) I would

N: (hhhh)

P: (hhhh) I'm making you giggle (.) and you shouldn't be doing that shouldn't you? (to R)

R: I'm doing it quietly (hh) (2.0s)

P: at least when you get grumpy ones later (.) you can think of that mad cow this morning (.) she made my day

N: (hh)

P: and I've got (incomprehensible) (hhh)

N: all we have is a laugh (4.2s)

P: at least I've got the excuse now (.) I can't write with this hand today ((looks at N))

N: (hhh) not in work today are you?

P: yeah I don't do any much writing (.) we I've got a bit of a shop (.) so I'll be alright

N: oh where is it? ((looks at P))

P: we've just opened it up (.) it's me and my son (.) it's just down (street name) (.) (name of shop) (.) it's like a little tea room and cake shop and we do celebration cakes and all sorts

N: don't tell us that

P: you'll be wanting cakes next time I come round won't you?

N: I love cake ((smiles))

P: I do as well

N: I love cake too much that I make myself=

P: =hence the size of me (smiling voice) (.) yeah (.) I don't do salad (hhh)

N: you could do a salad cake ((smiling))

P: I could try (.) yeah ((smiles))

N: could try

P: well actually=

N: =carrot cake ((nods)) (.) there you go

P: I have done (.) yeah (.) carrot cake

N: (hhhh)

P: I've actually done a cake that looked like a pizza

N: really?

P: yeah (.) for my son once (.) yeah

N: so is that like wedding cakes as well (.) things that you do

P: mmm (.) mmm (.) I'm just like betty basically

N: where is (street name)

P: oh it's just literally (.) over the road (.) round the corner (.) umm (.) from here if you come out the front door

N: oh::: I know

P: go to the end (.) turn right

N: yeah yeah

P: and we're just down the end

N: so is it past the church and up (.) that way?

P: yeah (.) you get to the (pub name) (.) you've gone too far

N: (hhhh) (0.9s)

P: that's what I usually say if you get to the (pub name) (.) you get to the pub (.) you've gone too far and you need to come back (hhhh)

N: so how long have you been open?

P: oh (.) just since about (.) February (.) March at the moment (.) yes

N: are you doing ok?

P: it's been quiet at first (.) but this month (.) I've got about f- is it four (.) yeah four celebration cakes (.) birthday cakes to do this month

N: yeah (.) brilliant (.) are you on Facebook and everything

P: yeah

N: ((N takes out needle)) press on that for me (0.5s) ((P presses on arm))

P: right (.) it was good that we were getting quite a few orders through that and everything that we said (.) look it would be better to have an outlet because it's got a kitchen and everything

N: yeah yeah (.) you need it (.) don't you?

P: yeah (.) cause although the homes were registered (.) it was easier if you've got a separate kitchen to do it in

N: you see (.) you're good because there used to be one in (place name) (.) do you remember? ((N starts writing on form))

P: there did

N: and that closed down (.) didn't it?

P: it closed (.) didn't it? (.) and then your other one's in town

N: yeah

P: well there was only those two (.) there's one down (street name) ((gestures in direction))

N: you're certainly word of mouth aren't you?

P: yeah (.) it is (.) yeah

N: I'll tell our staff

P: thank you ((whispered))

N: they'll probably know where you are

P: (hhh)

N: ((N looks up)) right (.) so they'll be done by Monday

P: right (.) so if I make an appointment for the back end of the week (.) or?

N: yeah (.) yeah

P: it'll be sorted ((P rises from chair)) (1.2s) that's alright to come off there now ((takes off plaster))

N: it should be alright (.) if you bruise (.) don't blame me

P: no (.) I won't (.) you're alright

N: (hhh)

P: you were quite gentle there (.) that's fine

N: so you can't panic now (.) you come back (.) see us (.) (incomprehensible)

P: that's it (.) I'll be alright (.) it's just when somebody else gets up and rams it in like ((squeals and makes face))

N: (hhh)

P: (hhh) ((P heads towards the door))

N: good luck with your shop

P: thank you very much=

N: =take care=

P: =see you again

N: bye now ((laughing voice))

Appendix 4: Tables reflecting quantitative analysis for Chapter 6

Terms of address for patients used by nurses in first turn summons

Nurse	First and second name	Title and second name	First name only	Total
1	1	1	0	2 (3%)
2	2	3	2	7 (10%)
3	4	0	1	5 (7%)
4	5	1	1	7 (10%)
5	3	7	0	10 (14%)
6	3	3	1	7 (10%)
7	3	1	1	5 (7%)
8	0	10	0	10 (14%)
9	2	5	1	8 (11%)
10	9	0	1	10 (14%)
Total	**32 (45%)**	**31 (44%)**	**8 (11%)**	**71**

Patient term of address according to patient age in first turn summons

Nurse	Younger (n=35)			Older (n=36)			Total
	First and last name	Title and last name	First name	First and last name	Title and last name	First name	
1	1	1	0	0	0	0	2 (3%)
2	1	2	0	1	1	2	7 (10%)
3	1	0	0	3	0	1	5 (7%)
4	2	0	1	3	1	0	7 (10%)
5	3	2	0	0	5	0	10 (14%)
6	3	0	1	0	3	0	7 (10%)
7	1	0	1	2	1	0	5 (7%)

8	0	5	0	0	5	0	10 (14%)
9	1	3	1	1	2	0	8 (11%)
10	5	0	0	4	0	1	10 (14%)
Total	18 (25%)	13 (18%)	4 (6%)	14 (20%)	18 (25%)	4 (6%)	71
Percentage of age group	51.5%	37%	11.5%	39%	50%	11%	

Patient term of address according to frequency of visit in first turn summons

	Never seen before (38)			Once or more (33)			
Nurse	First and last name	Title and last name	First name	First and last name	Title and last name	First name	Total
1	1	0	0	0	1	0	2 (3%)
2	1	0	0	1	3	2	7 (10%)
3	2	0	0	2	0	1	5 (7%)
4	5	0	1	0	1	0	7 (10%)
5	3	2	0	1	4	0	10 (14%)
6	1	2	1	2	1	0	7 (10%)
7	1	1	0	2	0	1	5 (7%)
8	0	5	0	0	5	0	10 (14%)
9	1	1	0	1	4	1	8 (11%)
10	9	0	1	0	0	0	10 (14%)
Total	24 (34%)	11 (15%)	3 (4%)	9 (13%)	19 (27%)	5 (7%)	71
Percentage of	(63%)	(29%)	(7%)	(28%)	(64%)	(8%)	

frequency group						

Length of consultation with amount of thanks used (range and average)

	Transaction length		
	Up to 600 seconds	Up to 900 seconds	Up to 1800 seconds
Number of interactions	65	17	16
Range of thanks used	0-4	0-3	0-4
Average number of thanks	1.25	1.3	2

Reason for consultation with amount of thanks used (range and average)

	Transactional consultation	Health Review Consultation
Number of interactions	76	24
Range of thanks used	0-4	0-4
Average number of thanks	1.315	1.708

# Appendix 5: Tables reflecting quantitative analysis for Chapter 7

Request forms of stage 3 of blood-taking process

Request	Number of instances	Older	Younger
imperative	15 (40%)	10 (59%)	5 (24%)
willing	1 (3%)	1 (6%)	0
permission	1 (3%)	0	1 (5%)
declarative	2 (5%)	1 (6%)	1 (5%)
Let's request	2 (5%)	1 (6%)	1 (5%)
Hypothesis	1 (3%)	0	1 (5%)
No verbal request	14 (37%)	3 (18%)	11 (52%)
P anticipates request	2 (5%)	1 (6%)	1 (5%)
Total	38	17	21

Request forms of stage 4 of blood-taking process

Request	Number
Imperative	17 (44%)
Hypothesis	3 (8%)
Ability	2 (5%)
Stage did not occur	17 (44%)
Total	39

Appendix 6: Nurse and patient mean use of humour for each transcript
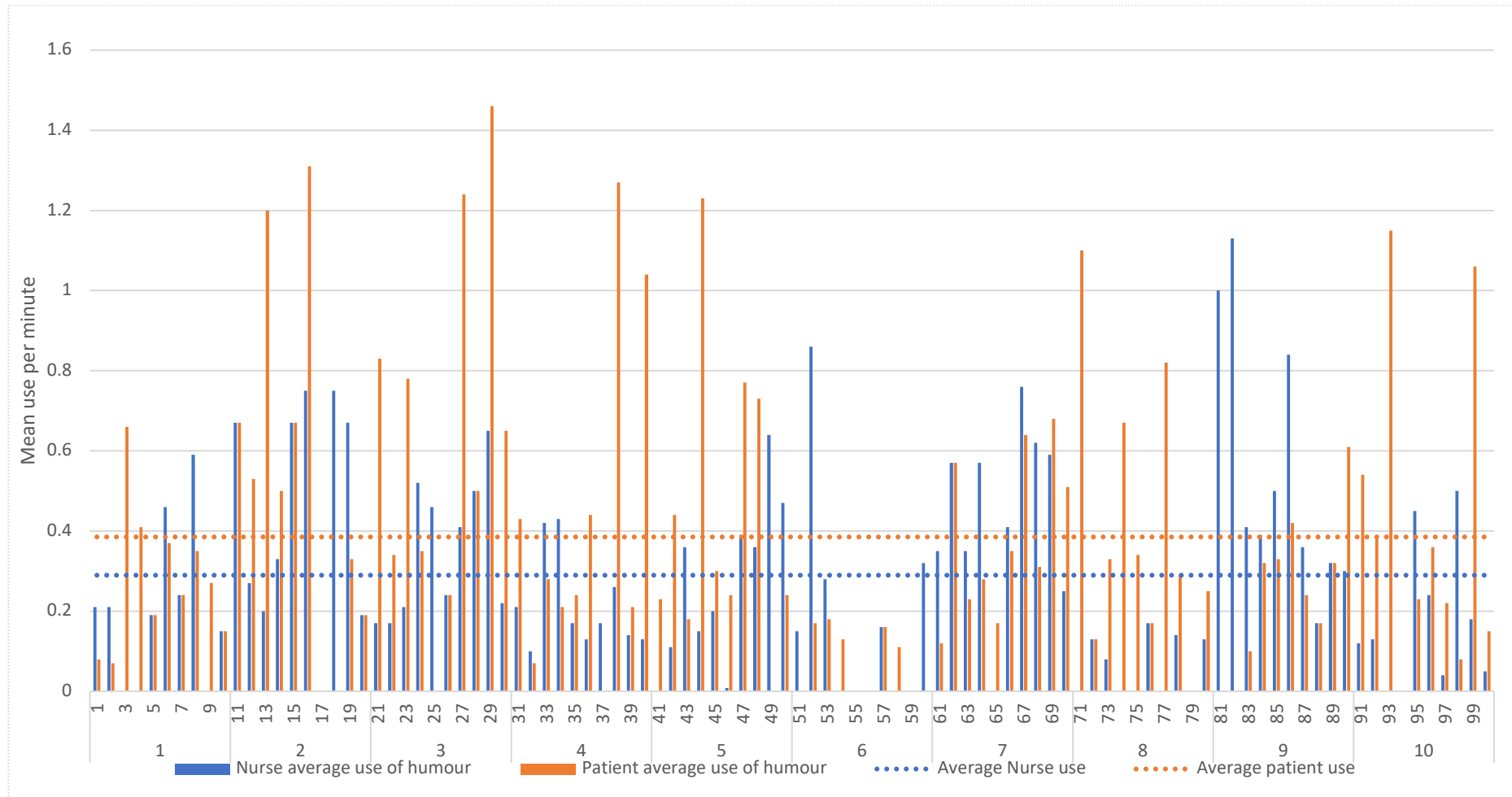
Appendix 7: The forms of humour used by nurses and patients shown via mean use per minute