The hospital bedside consultation: Doctor-patient interaction

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The thesis is being submitted in total fulfilment of the degree.
Declaration

I declare that:

(1) the thesis comprises only original work towards the Doctor of Philosophy;
(2) due acknowledgment has been made in the text to all other material used; and
(3) the thesis is fewer than the maximum word limit in length, exclusive of tables, transcript extracts, references and appendices
For my parents:

Andrew Morrison (1924 – 2010)

and

Barbara Morrison
Preface

Funding

During my PhD, I was generously supported by the following competitive funding scheme:
Australian Postgraduate Award, Australian Government, 2009 - 2012

Conference presentations

ICCA14 Conference, Los Angeles, USA
23-28 June 2014
I presented a paper entitled: “How are you? Questions at the bedside”. This paper looked at the role of questions and questioning during the bedside consultation, particularly during the consultation opening.

Communicating Health Symposium 2012 @ Melbourne, The University of Melbourne, 4 December 2012.
I presented a paper entitled “Silence during bedside consultations”. This talk used data from my PhD study to explore an aspect of bedside interaction I was examining at the time and thought was interesting an important.

Hospital name: Hospital Grand Round presentation, 2 October 2012
I presented a paper entitled: “How are you? Questions at the bedside” at the hospital where the data was collected. The aim of the presentation was to outline the research project and selected findings to date as feedback for the hospital staff. This paper outlined the study design and aims and discussed some of roles questions played in the data, illustrating points made by excerpts from the data.

The 2011 Australian Linguistics Society Conference, Australian National University, 2 December 2011.
I presented a paper entitled: “Doctor-Patient discourse: Silence in ward round consultations”. This paper developed the focus on the apparent functions of silence in
the consultation now in relation to various ethnographic features of the data such as participant roles/titles/characteristics (e.g. gender, seniority) and consultation type.

5ICOM Conference, University of Technology, Sydney, 3 December 2010
I presented a paper (co-authored with Dr. Barbara Kelly) entitled: “Doctor-patient discourse: A multi-modal investigation”. This presentation focused on the role of silence in interaction as evident in the data with relation to the communicative ‘effectiveness’ of the consultations. The concepts of communicatively ‘effective’ and ‘ineffective’ (or ‘less effective’) consultations was an early focus of research in this thesis later abandoned because it proved too elusive to meaningfully define and ‘capture’ in the data.

HCSNet Conference, Sydney, 1-4 December 2009
Presented a speed paper entitled “Doctor-patient discourse: A multi-modal analysis” I presented a brief outline of the initial aims and design of my PhD study. This presentation focused on a multimodal analysis of the data with the aim of producing a template for investigating the multimodal conduct of the consultation.
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Abstract

This thesis investigates the communicative work, organization and conduct of the participants in hospital bedside consultations occurring during daily ward round visits. Four research questions focusing on what happens during different phases of the bedside consultation and how these phases are organized as a whole, are the vehicle for the investigation. This structurally-based analysis shows how a distinctive set of constraints and imperatives are made relevant in the organization and conduct of the bedside consultation and distinguish it from other kinds of consultation.

Videotaped data from 48 bedside consultations recorded at an Australian hospital is analysed using a combination of Conversation Analysis and basic quantification. The thesis finds that participants in this under-studied setting encounter distinctive communication challenges and that these challenges are reflected/evident in activities and practices not found in other types of medical consultation. These findings contribute to our understanding of medical communication and have implications for medical education and the provision of optimal care for a group of uniquely vulnerable patients.
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Acronyms
CA   Conversation Analysis
RQs  Research Questions
SFR  Specialist Feedback Request
PFR  Procedure Feedback Request

Abbreviations used in transcripts
D   Doctor
D1  Second doctor
D2  Third doctor
JD  Junior doctor
P   Patient
N   Nurse
Chapter 1  Thesis Overview

1.1  Introduction

The daily hospital ward round, when inpatients are visited by their doctors to monitor their progress, is a frequent event. The bedside consultation is at the heart of the ward round visit, and it is a potentially high stakes kind of consultation for patient and possibly also doctor, occurring in an environment that is potentially medically, interactionally and emotionally intense and highly charged. Despite its frequent occurrence and prominence in the hospital routine of patient care, relatively little is understood about its structure and conduct.

The importance of the therapeutic relationship between patient and doctor has been recognized since ancient times. A medical encounter brings together a patient, with knowledge and experience of their symptoms, and a doctor or other healthcare practitioner with relevant professional clinical knowledge and skills, and access to an array of diagnostic and treatment equipment, procedures and resources. Nevertheless, the therapeutic encounter turns on an exchange of trust, acknowledgment, reassurance, examination, information, response and recommendation, all of which occurs in and through interaction between the parties. The interaction through which this exchange is achieved usually occurs face-to-face, and appropriate diagnosis and treatment of the patient cannot be delivered without it. It is for this reason that questions relating to the communicative conduct of the medical encounter are important to pursue and have been the focus of considerable research attention over many years across a diverse range of disciplines. A key question to consider concerns how this kind of multi-layered exchange is brought about, and this is the frame for the current investigation.

This study investigates the inpatient (in hospital) bedside consultation that occurs during the daily ward round visit, which is a medical consultation identified in earlier medical communication literature as needing further investigation, including with regard to its organizational structure at different levels, in order for its interactional processes to be revealed (O’Hare, 2008; Walton, Hogden, Johnson & Greenfield, 2016). Using a Conversation Analysis-type framework (henceforth CA) to examine data from actual consultations, the study presents a ‘portrait’ of the bedside
consultation and aims to show how this hitherto unexamined type of consultation plays out interactionally, how participants manage its distinctive interactional challenges, and how it is distinctive in comparison with medical consultations in other settings.

The following sections of this chapter introduce the subject, scope, motivation and design of the study, and outlines the organization of the thesis overall. It begins with a brief description of the bedside consultation, which is problematized in the context of its complexity, its participants, its place in the healthcare system and of our relative lack of understanding of how it unfolds, communicatively. Reasons for investigating the bedside consultation are outlined, as is the proposed research methodology, relevant research findings showing a gap surrounding the bedside consultation, and proposed research design for this study. A thesis outline and a summary of the contents of the next chapter, conclude the introduction.

1.2 The bedside consultation: What it is and why it is important to learn more about it

The hospital inpatient bedside consultation is a frequent, potentially high stakes encounter that occurs within a complex clinical context shaped by a variety of pressures and constraints affecting medical services, staff and patients. Despite its manifest importance as a site of patient care and clinical work, relatively little is known about how the bedside consultation works communicatively. The current study aims to help fill this gap by presenting an account of how this kind of consultation is done, and showing how it is similar but more importantly, how it is different from medical consultations conducted in other clinical settings.

It is important to improve our understanding of how doctors, patients, family members and other medical staff work together during the inpatient bedside consultation in order to provide an empirical basis for evaluating, and potentially improving, its quality and effectiveness. Participants in this kind of medical consultation have different and distinct vulnerabilities, and as members of a broader community and actors in institutional work in which their wider community is invested both ethically and financially, they need to have their efforts, actions and dilemmas better understood.
Inpatient hospital care is costly. Treatment and diagnostic equipment and processes are becoming more sophisticated across the Australian (and other) health system, and these are expensive to develop, build, purchase, maintain and operate. In addition to the high cost of equipment, hospitals employ a large professional and non-professional staff, and hospital buildings must be maintained and upgraded to facilitate high quality patient care. Attempts to optimize the efficiency of inpatient care aim to address the high cost of hospital care by reducing waste of money and other resources in hospitals. Measures designed to help achieve such efficiency include reducing patient stays in acute hospital beds to a minimum. This is achieved by sending patients home or to rehabilitation facilities as soon as possible rather than allowing them to recover fully in hospital, as might once have been the practice.

Measures chosen to address the cost of hospital care have political as well as practical dimensions. Funding for hospital care is generally at least partly derived from government sources, and Federal government policy in Australia links funding to the time patients spend in hospital beds.

Medical treatment, testing and diagnostic procedures are becoming ever more sophisticated and numerous, particularly in the developed world, as a result of advances in technology and understanding of disease processes.

At the same time, new patterns of disease are emerging that may challenge existing treatment priorities. For example, there are increasing rates of chronic ‘lifestyle’ diseases and of illnesses associated with old age and ageing ‘baby boomer’ populations. All the changes mentioned above have led to a greater cost burden on taxpayer funds and associated schemes effectively rationing different types of health care. These ‘rationing’ schemes include limits placed on the amount to time individual patients are allocated ‘funded’ hospital beds. This means that hospitals receive government reimbursement for only a certain amount of accommodation per patient. A consequence of this is that doctors are under pressure to discharge patients within this funding window to minimize their costs. As discussed below in Chapter 7, the impacts of this kind of policy shift may be evident at an interactional level.
It is important also to understand more about how the bedside consultation is conducted because it is the site of clinical training and professional socialization of medical students and junior doctors. There is clear value in understanding more about the kind of clinical and communicative practices that these future doctors are shown and practise under supervision in the course of their on-the-job training, so that it can be evaluated and confirmed, changed or adapted and findings incorporated into the development of medical training and professional development programs. So far relatively little is known about this issue and this study aims to contribute to our understanding of it.

A final reason to learn more about how the bedside consultation is conducted is to contribute to the broader stock of knowledge about “the character of the social interaction that underpins social life … [and forms part of] the extraordinary cultural variety of human social organization, communication and lifestyle” (Enfield & Levinson, 2006:2-3). This broader purpose of responding to the perennial human impulse of curiosity about itself and the world it inhabits is evident in this area of ethnographic research, which continues to grow and fascinate investigators working in a range of fields, including that of interactional sociolinguistics of which the micro-analytic methodology of CA is an increasingly prominent and fruitful part.

1.3 Previous research into the discourse of medical consultations

Previous research into the structure and conduct of medical consultations in other clinical settings has shown how participants orient to a shared understanding of the overall structure of the consultation. They do this collaboratively, using speech and embodied action to accomplish their work (Heath, 1986; Robinson, 1998, 2003; Robinson & Stivers, 2001). Participants’ conduct displays their responses to various constraints embedded in the context of the interaction, and it is in and through these responses that the constraints may be ‘seen’ and the distinctive character of the context. These constraints may stem from aspects of the physical or institutional setting, or by participants’ stance or preferences in relation to actions or propositions within the consultation.
More recent research has also focused on the hospital ward round (Ahmed, Ruttter & Nequaye, 2009; Monrouxe, Rees & Bradley, 2009; O’Hare, 2008), and on the inpatient bedside consultation, chiefly focusing on aspects of its educational dimension (Elsey, Challinor & Monrouxe, 2017; Rizan, Elsey, Lemon, Andrew & Monrouxe, 2014; Rees, Ajjawi & Monrouxe, 2013). The findings from this research are discussed more fully in the literature review in Chapter 2.

This study builds on that earlier work, dovetailing between the substantial body of research into medical communication in community clinical settings, especially involving general practice consultations, with the more recent research into the hospital medical encounter referred to above, much of which has a focus on the educational aspects of consultations in the hospital environment. This thesis addresses questions more often posed with relation to primary healthcare consultations, with regard to interaction in a hospital setting, namely features and issues related to the conduct and organization of the bedside consultation. In addressing these questions, this thesis aims to help fill the gap in knowledge about how it is done, and how (and whether) it is distinctive.

1.4 How this study addresses the research topic

To explore the interactional organization and conduct of the bedside consultation, this thesis takes a structural approach, using the methodology of CA to frame the analysis. CA analysis is underpinned by the notion that “actions delivered through sequences are at the core of human social life” (Clift, 2016:272), and that human interaction is profoundly orderly, displaying “order at all points” (Sacks, 1992a:xlvi). Action and sequence consequently form the basis of CA investigations, and CA methods provide the means to examine entire episodes of interaction or fragments of it to gain insight into how participants in conversation order their actions and activities to get things done through interaction.

The chief focus of this study will be the overall structural organization of the consultation at different levels: at the level of the ward round as a whole, at the level of the bedside consultation as a whole, then at the level of activities that comprise different components of the consultation, then of the internal structures of those
activities. It will also investigate what issues and dilemmas are made relevant to participants through the course of this consultation and how they work together to resolve them within the constraints of the activities of the consultation. These issues include the distribution of authority, negotiation about proposals presented by doctors for such elements of medical care that are relevant in this setting, the management of delicate issues, and the resources used to shape the progression of the consultation.

1.5 Thesis aims

This thesis aims to portray the bedside consultation focusing on how participants organize, structure and conduct this work, with a view to improving understanding of how it works, what issues it deals with and using that understanding to optimize clinical practice and training in this setting.

1.6 Thesis outline

This thesis is organized as follows: the present introductory chapter is followed by a literature review chapter discussing what is known about the hospital as an institutional setting and as a context for the bedside consultation, about interactional features of institutional discourse and medical discourse as well as the organizational structure of medical consultations. In Chapter 3, the data collected for this study is described, as are procedures used for its collection, storage and protection. A brief outline of the CA analytic paradigm and methodology is also provided. Study results are presented in Chapters 4, 5, 6 and 7. In Chapter 4, findings concerning the overall structural organization of the bedside consultation are reported. Chapter 5 describes how the bedside consultation is opened, Chapter 6 shows how the core medical business of the consultation unfolds and in Chapter 7, the closing of the consultation is described. In Chapter 8, findings reported in earlier chapters are discussed in the light of the four research questions of this study. Conclusions are presented, limitations of the research are acknowledged and evaluated, as are suggestions for future research.
Chapter 2 Medical Discourse

2.1 Introduction and the Research Questions

This study aims to explore and describe the unique communicative character of the bedside consultation as a whole and as a sequence of component parts. It does so on the basis of observations of data collected in a single hospital over an approximately one-year period. The methodology of the study is discussed in more detail in Chapter 3. The study is organized around the following four Research Questions (henceforth RQs):

RQ1 What is the overall structural organization of the bedside consultation?
RQ2 How is the bedside consultation opened?
RQ3 How does the business of the bedside consultation unfold?
RQ4 How is the bedside consultation brought to a close?

These questions were chosen to shape this study of the bedside consultation for several reasons. The first reason is that they comprise an approach for investigating communicative phenomena starting with a structural ‘overview’ of the consultation as a whole that creates a conceptual framework for looking in more detail at the component phases and activities.

The second reason for choosing these structurally-focused RQs is that there is a gap in our understanding of the organization of the bedside consultation, at the level of the consultation as a whole and as a grouping of interconnected parts, as well as how these components fit together.

The third reason is that there is a large body of structurally-based CA research into medical interaction (as well as research into mundane and institutional interaction in general). This research is a relevant and useful point of comparison for my findings. It is discussed later in this chapter, and helps position my account of the bedside consultation within a broader body of research documenting medical (and other) interaction. As well as providing a general empirical context for my findings, the CA literature on medical discourse and on the organization of medical consultations in
particular includes a substantial body of work focused on consultation openings (Coupland, Robinson and Coupland, 1992; Robinson, 1998, 2003, 2014; Robinson and Heritage, 2006; Heritage and Robinson, 2006; Heritage and Clayman, 2010) as well as on other activities in the medical consultation, including closings (Robinson, 2001; West, 2006), that correspond to my RQs.

The fourth reason for choosing the RQs outlined above is that they provide a platform for highlighting the distinctiveness of the bedside consultation compared with other kinds of medical consultation, not only with relation to findings in the CA literature but also with findings reported in a wider body of non-CA qualitative and other medical communication research. This research is also outlined in this chapter (§2.3), with a view to providing a broad empirical overview of what is known about the area of general and hospital interaction.

While a CA type analysis underpins the research presented here, I include additional analytic methods to CA analysis, so my research uses mixed methodologies, and is strictly ‘CA like’. A broad range of research in this area has also used a combination of CA methodology with some other kind of methodological component (Stivers, 2015; Heritage & Stivers, 2014; Clemente, 2014; Mondada, 2011), and for this reason I have included research into medical discourse conducted using a range of methodologies including but not limited to ‘pure’ CA methodology in this review.

The fifth and final reason for choosing my RQs is tied to this point. This broader body of medical communication research contains findings about interactional and other issues arising during medical consultations that the main analysis in my research may also throw light on. The capacity of my RQs to reveal issues beyond their core structural focus allows me to make these connections and explore them to the level of detail appropriate to my investigation. These issues include clinical education and training (§2.2.6), complexity in the organization of work and interaction in hospital settings such as the emergency department, during medication discussions and during nursing changeovers (§2.2.3), and the management of delicate moments during the consultation (§2.3.6). Delicate moments may include difficulties participants encounter facing uncertainty, anxiety or embarrassment. Other issues that have been
explored in the literature include the management of competing agendas, barriers to patient engagement and the role of invitations to laugh during the consultation, particularly with regard to managing delicate moments in the interaction.

The main focus of this thesis is the organizational structure of the bedside consultation at the levels of the encounter as a whole and of its component phases and activities. As mentioned above, while exploring how participants organize and enact the bedside consultation, interactional and other issues emerge that are not obviously structural, but which are evident in and through the work that participants conduct. Those seemingly non-structural issues mentioned above and taken up later in relation to the bedside consultation in Chapters 5, 6, 7 and 8, include: the challenges involved for consultation participants in managing delicate moments in the consultation (§2.3.6, §6.3.2.1), in pursuing competing agendas (§2.3.3, §6.3.5 §8.3.5) establishing and asserting authority (§2.3.2; §5.3.3, Extract 20, Figure 15; 6.3.1, Extract 31) and meeting face needs (§2.3.1, §5.3.4, 5.3.6.2).

CA is a method of investigating social interaction discussed in more detail in Chapter 3. It aims to discover the underlying structures that participants recognize and use to co-construct meaningful encounters. While CA looks no further than interaction to identify the structures participants in interaction make relevant to do their interactional work, other medical communication research incorporates additional ethnographic features of interaction and uses other qualitative research methodologies to interpret data. I also incorporate additional ethnographic features of the data into the data analysis, and the organization of the study around the four structurally-based RQs also allows me to do this. Issues surrounding the methodology of this study are addressed in more detail in Chapter 3.

In organizing this account of the bedside consultation around its organizational structure at different levels, not only is the gap in our understanding of this important but until recently, overlooked, kind of medical consultation addressed, but similarly under-studied activities or practices that occur during the bedside consultation may be revealed. Such issues have been identified as topics for further research and include
how doctors manage discussion about potentially sensitive or complicated issues at the bedside (Collins et al., 2005; O’Hare, 2008; Riva et al., 2014).

By setting the activities of the bedside consultation within the broader context of the consultation as a whole, the orientations of participants, some of which have been explored in other work, can be seen in a broader interactional and institutional context. In looking at the consultation as an entire event, hitherto less explored activities are also seen in context, as are the dilemmas that participants face in the consultation. In the process of describing the overall structural organization of the bedside consultation, some other outstanding questions arise: evidence of pressure for beds, and how participants manage discussion of potentially complicated or emotionally challenging issues.

This thesis is chiefly motivated by a sociological “concern to witness and document naturally-occurring social interactions in medical settings” (Pilnick, Hindmarsh & Teas Gill, 2009:3). Observing and describing the data in this way may yield empirically-based insights into structures and practices used by participants in their work. These structures and practices may help patients engage with the tasks of the consultation and help doctors optimize some aspect of their clinical practice in caring for hospitalized patients or training the next generation of doctors in the bedside consultation as they “organize their work routines and engage in (and display) sense making practices in real time” (Pilnick et al., 2009:789).

Despite the diverse array of findings medical communication research to date has produced, a range of which has been outlined in this chapter, there is yet to be a ‘portrait’ study of the bedside consultation as a complete event occurring within the context of the daily ward round visit. Such an overview of the consultation could help to bring together different facets of research findings about interaction in the hospital and at the bedside consultation in particular, in medical consultations in general. This could help us understand more about how doctors, patients and others in this important, daily, multiparty encounter orient to social and institutional structures to co-construct their work, pursue their agendas, deal with sensitive issues and manage dilemmas that this work encompasses.
Research, such as that by Lyn Monrouxe and Charlotte Rees (e.g. Monrouxe, Rees & Bradley, 2009) has recently begun to show different aspects of how participants in the hospital bedside consultation (and in other hospital encounters) use interaction in various ways to do their work and manage its challenges (discussed in §2.2.4). However, we do not yet know how they refer in and through their interaction to larger structures in shaping this work.

This question is interesting because it reminds us of the fact that medical interactions (and all others) occur in a wider social context, and people’s understanding of where their current activity fits within that context is evident in what they do, turn by turn, activity by activity, phase by phase. People display an understanding of the place their current activity occupies within a wider social order through their actions (Pilnick, 2005).

In the bedside consultation, such insights into participant understandings could help show how institutional imperatives as well as local interactional issues, affect the experience of vulnerable participants in the provision of inpatient care. In addition, we have much to learn about how structures and dilemmas described in relation to the work and organization of the medical consultation in primary and secondary healthcare settings (discussed in §2.3) are realized in the inpatient setting (explored in Chapters 4-7). Questions this gap raises include whether the bedside consultation has unique structural and organizational characteristics, and interactional dilemmas, and if so, what they are.

My research in the current study dovetails between two bodies of medical communication research: a recent research literature about interaction and other activities in the hospital setting (§2.2), and a much larger, well established body of research about interactional practices and activities in the community setting (§2.3).

There is a growing body of research into healthcare in the hospital setting, including at the bedside. Much of this research is focused on generating findings about teaching and other interactional practices in consultations that can be used to inform medical
education (§2.2.6). A number of recent hospital-based studies have been produced in or in close association with medical schools (Ajjawi, Rees & Monrouxe, 2015; Monrouxe, Rees & Bradley, 2009; Monrouxe, Shaw & Rees, 2017; Urquhart, Ker & Rees, 2014; Paul, 2015).

Another much larger body of medical communication research focuses on an array of topics related to healthcare provision in community settings, largely in primary healthcare (e.g. in G.P. or general practice consultations) but also in secondary healthcare (e.g. in specialist practices such as surgeon visits or psychiatric consultations) and other ancillary medical settings (e.g. in physiotherapy or homeopathy consultations) (see §2.3).

While the larger body of community-based research has a wide range of emphases and focuses, hospital-based communication research is characterized largely by institutionally relevant objectives and often has an educational and safety focus (Anspach, 1988; Pomerantz, Ende & Erikson, 1995; Herke, Matthiessen, McGregor et al., 2008). In addition, medical communication research is increasingly being conducted in interdisciplinary groups, and this approach characterizes the bulk of the investigations into hospital interaction (Manias, Rixon, Williams, Liew & Braaf, 2015). Interdisciplinary research (or ‘interdisciplinarity’) brings together different research disciplines, which at once enriches investigations with the involvement of different perspectives, and exposes it to the potential threat of being weakened or compromised by conflicting methodological and analytic agendas resulting from researchers in the different fields coming together (Pilnick, 2013).

Within these two related but distinct bodies of research, one topic is less well represented: that of the overall structural organization of the consultation as a whole. In the larger body of research focused on healthcare interactions in community settings, this aspect of the medical consultation has been described, however that work has been conducted in the inpatient hospital setting, it is yet to be closely examined. This gap has been noted by researchers investigating interaction in the hospital setting, who have suggested that more needs to be understood about how participants organize
the consultation structure as a whole as well as its component parts to accomplish their work (O’Hare, 2008; Walton et al., 2016).

It is this gap in the literature that this thesis addresses, presenting a ‘portrait’ of the bedside consultation. In shaping this account of the bedside consultation around its organizational structure at different levels, not only is this gap in our understanding of this important but until recently, overlooked, consultation filled, but similarly understudied activities or practices may be revealed. Within the framework of a ‘Portrait of the bedside consultation’ glimpses are revealed of learning processes, distinctive interactional practices both between dyads and within the multi-party environment of the bedside consultation. Such issues have previously been identified as topics for further research and include how doctors manage discussion about potentially sensitive or complicated issues at the bedside in situ (Collins et al., 2005; O’Hare, 2008; Riva et al., 2014).

The process of describing the overall structural organization of the bedside consultation reveals evidence of issues participants manage in and through the consultation that may not seem overtly structural. These issues include pressure for hospital beds, as well as the treatment of delicate or sensitive matters that may arise overtly or implicitly during the consultation. They present consultation participants with interactional challenges of how to acknowledge, confront or avoid these matters in the consultation.

In this chapter, I contextualize the current study within the large and still burgeoning body of medical communication literature discussed above. Because of the volume of research in this domain, I discuss a selection relevant to the focus and topic of my thesis: the organization and conduct of the bedside consultation that occurs during the daily ward round, as well as dilemmas participants in medical consultations have been shown to confront. My review is organized around what we know about interaction in hospital healthcare (§2.2) and in community healthcare (§2.3).
2.2 Interaction in hospital healthcare

In this section, I discuss the institutional and interactional settings of medical discourse and the place of medical care in the hospital, with a view to providing an ethnographic and interactional context for this study. I also outline some key ideas about institutional interaction (and interaction in general) to provide a conceptual background for this study. I begin with a discussion of the notion of ‘context’ to clarify understandings of this widely-used term that are relevant in this study.

2.2.1 Context

Context is a widely-used and complex notion which is an important resource for making sense of and describing phenomena of all sorts, across many fields including those investigating interaction. How can context be understood, and how can we use it to enhance our understanding of the bedside consultation?

Context is a concept that helps us make sense of something being examined in relation to a surrounding space or larger environment of some kind within which a phenomenon occurs. In relation to interaction, this larger environment is framed as some kind of larger social environment. Within paradigms of language and interactional investigation, context can be thought of in two ways (Sidnell, 2010).

Context can be understood as ‘big picture’ ‘macro’ social or physical surroundings within which interaction occurs. These ‘big picture’ contexts can include such elements as social class, cultural environment and institutional or physical setting. This idea of context is sometimes referred to as the “bucket” conception of context (Heritage & Clayman, 2010:20), where context is viewed as a container for what happens within it (Clift, 2016; Drew & Heritage, 1992). This is perhaps a usual general understanding of context and casts context as being a somewhat static phenomenon.

By contrast, interactional context can also be viewed as the immediate interactional environment in which an action occurs. This second notion is central in CA, where actions, particularly in interaction, are regarded as being “Context shaped …[and] context renewing” (Drew & Heritage, 1992:18). This interpretation is more dynamic
than the ‘bucket’ approach, and it expresses the idea that each turn at talk or action is formulated in response to the speaker’s analysis and understanding of the meaning and implications displayed in the prior action or turn. In this way an interactional turn is both responsive to and shaped by its prior turn, and at the same time forms the context for the next turn. The following turn is similarly responsive to the design of its prior, and so on until the end of the interaction, when the exchange “does not simply end but is brought to a close” (Schegloff & Sacks, 1973:69). The issue of closing, and how this is achieved is discussed in §2.3.1 and also in Chapter 7 in relation to the bedside consultation. This model conveys the dynamic rather than fixed nature of context.

CA scholars point out that, crucially, for contextual features to be relevant, they must be relevant to participants in interaction and be shown to be so in the design of participants’ turns or actions (Sidnell, 2010; Goodwin & Duranti, 1992). For example, a child invokes the role of ‘host’ when he claims the next turn because the game that he and his friend are playing is taking place at his (the host’s) house. However, the rules of the game (and the associated roles for the occasion as players of the game) are invoked by the second child when he responds: “that’s not fair, you just had a turn” (Sidnell, 2010; 246).

This example illustrates how a range of different contextual features can be and be shown to be made relevant by participants in interaction, sometimes multiple contextual features simultaneously, and that these contextual relevancies can and often do shift over the course of time, including over the course of a single interactional event. This complexity is expressed in the observation that participants are situated within multiple contexts which they can “rapidly invoke within the talk of the moment…[and]…which are capable of rapid and dynamic change as the events they are engaged in unfold” (Goodwin & Duranti, 1992:5).

### 2.2.2 Institutional interaction

Institutional interaction contrasts with ‘ordinary’, ‘everyday’ or ‘mundane’ interaction as interaction that is oriented to the accomplishment tasks aligned with the goals of social institutions such as courts of law, religious institutions, schools or other educational institutions, or medical institutions such as community- or hospital-based
medical clinics. Heritage and Clayman (2010:18) discuss seeking distinctive institutional practices that comprise a ‘fingerprint’ of particular institutional contexts. How does interaction occurring within particular institutional contexts distinguish itself from that produced in other institutional settings? In particular, what clues are there to identify a ‘fingerprint’ of the bedside consultation?

The idea that action and interaction between people in face-to-face encounters are fundamental components of human society and sociality underpins social research in fields ranging from anthropology through psychology, linguistics and sociology (Enfield & Levinson, 2006). This research is driven by the idea that social interaction is deeply, inherently and recognizably orderly to participants in interaction. These participants cooperate to organize actions into meaningful sequences and blocks of sequences in different social contexts. In doing this, participants in interaction respond to particular local (situated) constraints and affordances and create different and diverse social contexts. In doing this, participants in interaction, who are also members of communities, recognize, use, comply with or resist normative interactional rules and practices in mutually intelligible ways. These rules and practices originate in culturally specific and sometimes universal shared systems of beliefs, values and expectations (Enfield & Levinson, 2006; Stivers, Enfield, Brown, Englert, Hayashi, Heinemann, Hoyman, Rossano, de Ruiter, Yoon & Levinson, 2009; Stivers, Enfield & Levinson, 2010).

‘Ordinary conversation’ is often regarded as the baseline, default form of interaction against which structural and interactional norms and variations are pegged. Institutional talk occurs in non-social settings where some particular work is done that relates to the priorities and aims of a particular social institution. These institutions include (although are not limited to) those of education, the law, religion, public administration and healthcare. Institutional interaction is characterized by orientation by participants to institutional aims and constraints on the form and type of contribution considered relevant and allowable (Levinson, 1992), and by participants orienting to institutionally relevant roles.
Indeed Heritage & Clayman (2010) refer to the notion that social institutions are talked into being (Heritage & Clayman, 2010:20), by participants assuming roles such as teacher, student, judge, barrister, accused person, priest, congregant, shopkeeper, customer, doctor, patient. In taking on these roles, participants invoke particular types of relationship with each other and associated particular ways of talking together (e.g. doctors maintaining a ‘professional’ emotional detachment and objectivity). In doing this, “the parties are embodying for one another the relevancies of the interaction and are thereby producing the social structure” (Schegloff, 1992:110. [Italics in original]).

Institutional interaction is distinguished from ordinary talk in several ways. It is task-focused and “goal oriented in institutionally relevant ways” (Drew & Heritage, 1992:22), and has associated constraints on what contributions are treated as allowable. It is also characterized by asymmetries associated with the participants’ institutionally relevant roles, which are generally expert/lay person as discussed above. With these roles comes asymmetrical distribution of access to relevant specialist knowledge, rights to the floor and associated participation (Drew & Heritage, 1992; Heritage & Clayman, 2010; Pilnick & Dingwall, 2011) between participants. The ‘expert’ participant, representing the institution, generally has the right to manage the progress of the interaction and adhere to an institutionally relevant agenda through the encounter. There may also be asymmetry in the participants’ perceptions of the occasion of the interaction, which may be ‘routine’ for the institutional representative (e.g. doctor) and unique and unfamiliar for the lay participant (e.g. patient) (Drew & Heritage, 1992). The relationship between doctor and patient in hospital interaction is discussed in §2.3.4.

2.2.3 The hospital

What is the hospital? What is its history and what role does it play in the delivery of healthcare? How is patient care delivered in the hospital setting? In this section, I summarize a range of current ethnographic and interactional research about the hospital.
The hospital is distinctive as a site of healthcare delivery compared with community-based clinical settings because it provides both primary (chiefly emergency) and secondary outpatient (clinic-based) care, as well as inpatient care. The hospital also differs from community-based healthcare settings in a number of important ways: in its scale, its organizational complexity, and in the range of its functions. The hospital provides residential inpatient care in purpose-built facilities and its operation is governed by a complex set of interlocking routines through which its clinical, administrative and other services are administered and delivered. The cost of running hospitals is high and funding may be contested. As a clinical setting the hospital is described as a ‘non-place’ because of its relative anonymity, its temporary status as a place of accommodation and its lack of status as a part of the cultural history of a community (Auge, 1995).

As a social institution, the hospital has a history extending back beyond the 9th century BC in a range of places from Mesopotamia to India, Egypt, Iran, Greece, Switzerland and what is now Sri Lanka. (Bynum, 2008; Gormley, 2010). Its name derives from the Latin root ‘hospes’¹ and the Middle English word ‘hospital’ is first known to have been used in the 14th century, is derived from the Latin ‘hospitalis’ (‘guest’), through the Medieval Latin ‘hospitale hospice’, meaning (‘guest house’). The function of the hospital has shifted from being a periodic facility for rest and healing in times of epidemics, illness or conflict, often attached to religious institutions such as monasteries or temples, at times also a refuge for the poor, to the permanent institution of the modern hospital, begun in the 18th century, where organized medical training and collection of statistics occurred alongside care of the sick and dying.

The bedside consultation occurs in the clinical setting of the hospital. The World Health Organization defines the contemporary hospital in the following terms:

“[the hospital is] an integral part of the medical and social organization which is to provide for the population complete health care, both curative and preventative; and whose out-patient services reach out into the family in its home environment. The

¹ hospit- (‘stranger, guest’) -alis’ (‘of a guest’) from which is derived the Latin root ‘hospit-‘with the addition of the suffix –al (‘with the character of’); Merriam-webster.com, ewonago.com.
hospital is also a centre for the training of health workers and for bio-social
research….” (Sekhar, 2008)

The hospital is, as observed above, a long-established institution. The fact that it that
is traditionally and continues to be a site of data collection and clinical training as well
as patient care brings a distinctive complexity to the work and interactions that occur
there. This complexity has been examined and described in terms of interactions in
the emergency department; also nursing changeovers (Watson, Manias et al., 2015;
Manias, E., Geddes, F., Watson, B. Jones, D., & Della, P., 2015; Rixon, S., Braaf, S.,
Williams, A., Liew, D., & Manias, E., 2017), discussion between pharmacists and
medical staff about medications (Rixon et al 2015; Manias, et al 2015), barriers to
patient engagement in specialty hospital settings (Manias et al 2015), the impact of the
physical environment on interaction in the setting of the hospital ward, (Liu, Manias et
al., 2013), among others.

Hospital-based communication research also includes investigations of the impact on
patient safety of particular activities and processes that occur in the hospital. These
activities and practices include nursing clinical handover (Eggins & Slade, 2016;
Eggins, Slade & Geddes, 2016; Rixon, Braaf, Williams & Manias, 2017; Johnson,
Sanchez, Suominen, Basilakis, Dawson, Kelly & Hanlen, 2014), medication
discussions (Borrott, Kinney, Newall, Williams, Cranswick, & Manias, 2017), online
commentary in the emergency department (Heritage, 2017) and communication
practices in the emergency department (Herke, et al., 2008). Non-observational
research into supervision provision, especially in emergency departments has also been
produced, often based on survey and interview data and analyzed using mixed methods
(Orman & Thornton, 2010).

The hospital is a complex environment where multiple activities are conducted by a
large and varied staff. A large recent study links this complexity with risk. These two
issues are investigated in relation to hospital healthcare provision in a large Australian
study of a hospital emergency department (Slade, Scheeres, Manidis, Iedema,
Dunston, Stein-Parbury, Matthesen, Herke & McGregor, 2008; Slade, Manidis,
Risk is not a focus of the present study, but the complexity of the communicative work done at the bedside is a focus, as are questions of what factors may contribute to and result from the complexity of communication in this setting. I refer to this research described because of its clear illustration of the complexity of hospital work, routines and procedures.

2.2.4 The ward round

The ward round is a key aspect of inpatient medical care in a hospital setting. It can involve a single doctor visiting his or her patients each day (or at other intervals in some circumstances) or, in the setting of a teaching hospital affiliated with a university-based medical training program, a medical team visits the patients. Such medical teams usually comprise several doctors with a range of degrees of professional experience and seniority, including junior doctors, as well as medical students and sometimes also allied health workers such as nurses or dieticians. This team may be referred to as a Clinical Teaching Unit or CTU (Bates & Ellaway, 2016).

The order in which patients are seen on a ward round can be determined in different ways. They can be seen in an order that prioritizes the sickest patients, or those being discharged that day, or those with infectious diseases first or last (Cohn, 2014). There is also a choice the medical team makes about whether to visit patients as an entire team, or to divide up the case load between them in an approach colloquially known as ‘divide and conquer’ (Cohn, 2014; Reece & Klaber, 2012).

What do we know about the detail of the ward round and its structural components? How much more do we know beyond a broad outline of its parts, however important that knowledge is? The ward round has been described in terms of its phases, and of the activities and tasks undertaken during its course (O’Hare, 2008). These phases have been named as: collecting notes, the bedside consultation and the patient discussion (Creamer, Dahl, Perumal, Tan & Koea, 2010). The ‘collecting notes’ phase of the visit usually occurs outside the patient’s ward, often in the corridor, and involves a discussion between the team members of the important features and issues relevant to the particular patient ‘case’. However, this phase may occur in a separate room where the medical team discusses all the patients in that day’s round at length.
before the round begins. In this case the round consists of this ‘collecting notes’ meeting followed by shorter bedside visits to each of the patients. (Cohn, 2014).

The ward round is a complex event shown in the literature to have many variations in terms of attendees, location in the hospital routine, duration, purposes and component activities. For this reason, it remains ill-defined and difficult to describe clearly and unambiguously. Based on their review of recent literature, Walton et al (2016) identify eight ward round sub-types, the purposes of each sub-type and also participant categories and roles. These are listed in Appendix 1. They claim the first comprehensive framework of ward round types that describes the purposes of each type, attendees, their roles and participants’ perceptions of each other, using information and descriptions drawn from their literature review. Walton et al (2016) are not the first to describe ward round types and purposes (see Ahmed et al., 2009; O’Hare, 2008; Kirthi, Ingham, Lecko, Amin, Caldwell, Desai, Herring, Temple, Hughes, Soong, Curry, Duff, Lees, Abdi, Stewart, Patterson & Davies, 2012; Cohn, 2014), but their classification model is the most detailed and recent, and for this reason it is outlined in the following sections.

Walton et al. (2016)’s framework describing different types of ward round is comprehensive, however the authors acknowledge a lack of clarity in the literature, and some category descriptions remain vague. Consequently, there remains room for further development of their work outlining the range and type of ward rounds undertaken in hospitals.

Traces of earlier rounding practice remains in some hospitals and embodies cultural shifts in institutional relationships. Ward round visits led by a single specialist consultant accompanied by junior doctors (a registrar and resident) originates in an earlier system in Australia and elsewhere where specialist doctors donated their professional services at public hospitals as ‘honorary’ consultants. These ‘honorary’ doctors worked independently and trained junior doctors accordingly, in a practice that survives to an extent in private hospitals. The contrast between this version of the traditional ward round, and that of the multi-disciplinary model currently being promoted in contemporary hospitals embodies the cultural change in healthcare
delivery where doctors have progressively shifted from being self-employed independent professionals to being employees of healthcare providing institutions (Bradfield, 2010). The shift in doctors’ status from independent operators to employees has placed them in the same category as other hospital employees and has been accompanied by a growing move to teamwork in hospital patient care, exemplified by the model of the multi-disciplinary ward round which is promoted as desirable and a way of optimizing patient care and safety (Garling, 2008).2

The daily ward round is often carried out under pressured conditions due to time or staffing constraints, and in an environment where there are often distractions affecting the concentration of doctors and other staff involved. In addition, information may be omitted or missed because it is presented but ignored or overlooked during decision-making processes (Peadon, Caldwell & Oldmeadow, 2010)3. If junior medical staff work reduced hours, and they are inadequately supervised by senior doctors, their inexperience or lack of familiarity with patients’ situations, may result in them inadvertently making errors (O’Hare, 2008; Garling, 2008; Bradfield, 2010). As a consequence of these difficulties, there is the potential for an increased risk of error and resulting threats to patient safety (Bradfield, 2010; Launer, 2013). There is also potential for a loss of continuity of care due to increasingly varied staff working hours, shorter patient hospital stays, and the moving of patients between wards to address accommodation constraints and demands (O’Hare, 2008).

2.2.5 The bedside consultation

What do we know about the bedside consultation? The bedside consultation is the part of the ward round when each inpatient is visited at the bedside by his or her doctor with or without an accompanying medical team. How is the bedside component of the ward round structured? How are the tasks within it organized and conducted? What issues or dilemmas do doctors, patients and others involved manage together? The

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2 Bradfield (2010) argues that despite evidence that multidisciplinary rounds have a range of benefits for staff and patients, more evidence is needed to show that they result in better outcomes for patients.

3 For example, participants who arguably should be present because of the value of the information and perspective they could contribute, notably nurses, may be absent (Cohn, 2014). If nurses are absent because they are too busy, or because of reductions in the number of nurses employed, or because doctors perceive them as having too little to offer due to their place low on the medical hierarchy, their observations and comments are missed.
broad structure of the ward round has been described, as have particular aspects of its work, but to date there is little in the way of an integrated account of the bedside consultation at different levels: its overall structural organization, its key activities, conduct and challenges.

The bedside consultation has been identified as a distinct type of medical consultation (Sarangi, 2000), and it is sometimes referred to the bedside teaching encounter (or BTE) in research focused on the educational facet of its work (Ajjawi & Rees, 2015). The label BTE reflects the focus of the research where it is used. In other research, no distinction is made between the ward round and the bedside consultation.

The consultation between patient and doctor/s at the bedside is the focal point of the hospital ward round visit, which is itself a key component of acute and general inpatient hospital care (O’Hare, 2008; Hodgson, Jamal & Gayathri, 2005). As such, the bedside consultation is one of the most important and frequent types of medical encounters in the healthcare system. It has been described as “the central marketplace of information” in the hospital (Weber, Stockli, Nubling & Langewicz, 2007:246). Its organization has been described as consisting of the activities of: “Validating history and physical examination, refining the diagnosis, prognosis formation, treatment planning, discharge planning, interdisciplinary communication, cost analysis, priority setting, patient communication, communicating with relatives, teaching” (O’Hare, 2008:311).

2.2.6 Education and teaching at the bedside

A distinctive aspect of the work of the bedside consultation is the fact that medical education may be incorporated into patient visits. What education occurs at the bedside and how is it delivered? How does this education combine with patient care? Does it have an observable impact on the interaction or organization of the consultation? If so, what impact does it appear to have? Recent research has shed light on some of these questions, as has some older work on clinical education and teaching and learning practices.
The Royal Australasian College of Physicians (2013) states that graduates from its training programs will (among other attributes) “be able to communicate effectively and sensitively with patients and their families, colleagues and other allied health professionals” (RACP, 2013:8) as components of their “professional qualities”. Communication is listed first among learning domains in the professional training curriculum, within which identified themes include: “engage and reassure the patient in specific situations including: first encounters, history taking, counselling and breaking bad news” (RACP, 2013:20). Skills listed as being necessary for this to be achieved include being able to “build rapport with the patient; demonstrate active listening, use body language appropriately” (See Appendix 2).

Much research into interaction during the bedside consultation focuses on issues related to teaching junior doctors and medical students, the development of medical ‘professionalism’ (Monrouxe, Shaw & Rees, 2017), and the allocation and (re-) distribution of roles for the consultation that have been observed to occur (Monrouxe, Rees & Bradley, 2009). It also looks at how teaching and patient care coexist at the bedside with opportunities for learning negotiated during the consultation and participants taking on a range of roles in the process (Ajjawi & Rees, 2015).

Bedside consultations are a recognized in the medical education literature as a traditional site for the teaching of ‘communication skills’ and other dimensions of clinical competency to medical students and medical interns (Ajjawi, Rees & Monrouxe, 2015; Paradis, Pipher, Cartmill, Rangel & Whitehead, 2017; Bacchus, Ward, Grood & Lamaire, 2017; Bates & Ellaway, 2016; Janicik, Kalet, Schwartz, Zanbar & Letman, 2007). These studies focus on the perspectives of the supervising doctors (Lamaire, Wallace, Sargious, Bacchus, Zarnke, Ward & Ghali, 2017), medical students (Tanzin, Ahmed, Master & Uddin, 2018), structure of clinical teaching programs (Sheehan & Wilkinson, 2018), provision of feedback (Urquhart, Ker & Rees, 2018; Ajjawi, Molloy, Bearman & Rees, 2017; Rizan, Elsey, Lemon, Grant & Monrouxe, 2014) and the processes supervising doctors and junior doctors use to achieve shared understanding of work to be done (Olmos-Vega, Dolmans, Guzman-Quintero, Stalmeijer & Teunissen, 2018). There are also findings about the presentation of patient cases to ward round teams, and formulating treatment plans.
‘Communication skills’ have been described as including “…core communication skills [that make it possible for clinicians to] communicate with patients in general, assess a patient’s problem and situation, develop and maintain a relationship with a patient, give an oral presentation, complete a patient write-up, educate and counsel a patient, organize an interview and manage time, negotiate and share decision-making with a patient …” (Janicik et al., 2007:6). Among these ‘skills’ are: [to] ‘give an oral presentation’, which is part of the case presentation. However, from the perspective of the medical education literature, there is a perceived lack of a “…systematic description of the structure, language, and function of the OCP [Oral Case Presentation] from the linguistic standpoint…” (Chan, 2015). Chan concludes:

“…The significance of building a model based on expert–novice performance is that it will be a model anchored in the discourse community from which the model is derived and in which it will be used. Such a model will incorporate and reflect the language patterns, practices, ideology, and culture of the said community.”

The case presentation is an activity where junior doctors present key facts about a particular patient’s condition and current treatment to his or her colleagues and superiors. This may occur during a ward round or at a separate regular scheduled meeting in a dedicated meeting room elsewhere in the hospital. The case presentation is an activity that has not been studied much using a micro-analytic methodology.

The case presentation that takes place ‘on the wards’ (rather than in a meeting room) is part of the traditional training of junior doctors and medical students, and it has been the subject of attention of researchers with a view to exploring how its linguistic character projects a relationship between doctor and patient, hence providing a socializing device for medical discourse in this setting (Lang, Demousi & Lewis, 2017). Calls have also been made for more empirically based practical guidance for doctors and others involved in medical education to refer to in achieving consistency and a better-defined shared understanding of what constitutes good quality and
effective case presentations (Chan, 2015). These calls have been responded to in a concise form with regard to case presentations for pharmacists (Grant & de Val, 2016).

However, questions remain. How does the case presentation play out at the bedside? How is it organized, and does it have a single form and set of functions or more than one? If so, what is the range of purposes the presentation achieves and how is this managed by participants?

Anspach (1988) observes that the case presentation has the dual purposes of summarizing and reporting information about patients to colleagues, and also self-presentation as part of professional socialization. Anspach (1988) describes key linguistic characteristics of the case presentation: “the separation of biological processes from the person (de-personalization); … omission of the agent (e.g. use of the passive voice; …treating medical technology as the agent; and … account markers such as ‘states, ‘reports’ and ‘denies’, which emphasize the subjectivity of patients’ accounts” (p. 357). Anspach (1998) goes on to claim that this language has the effect of “eliminating judgment from medical decisions and mitigating responsibility for medical decision making…. enhancing the credibility of the findings that are presented … minimizing the import of the patient’s history and subjective experience…. [and] socializing’ those who present them to a culture or world view which may contradict the explicit tenets of medical education.”

2.2.7 Participant roles, relationships and identities at the bedside

What do we know about the roles participants in the bedside consultation assume, and how these identities and roles shape the way they relate to each other through the consultation?

Much recent research investigates the roles and relationships doctors, patients, students and others assume during the bedside consultation through the lens of the educational dimension of the work of the consultation. Such research also looks at what participant use of pronouns shows about their inter-relationships (Rees & Monrouxe, 2008), and how pronouns, like other interactional resources, can be used to mark relationships
between participants in interactions during what Rees & Monrouxe (2008) call the Bedside Teaching Encounter (or BTE).

Recent research explores how doctors and trainee doctors understand and co-construct multiple interactional identities through talk and other means in the bedside consultation (Monrouxe, 2010). Monrouxe, Rees & Bradley (2009) show how interactional resources can be deployed to assign roles to, and position participants in BTEs. However, because consultations in inpatient hospital settings may operate as contexts for medical education they may consequently function as a triad of doctor-patient-(medical) student rather than the doctor-patient dyad that characterizes interactional conduct in other clinical settings (Elsey, Challinor & Monrouxe, 2017).

A teaching ward round can have either an implicit or explicit teaching focus overall, or the teaching focus can shift between consultations. This point is made in prior research showing how BTEs can be organized to highlight important teaching points by fixing an otherwise flexible role allocation between participants. They show that during teaching encounters at the bedside involving senior and junior doctors in the presence of the patient, participants play various roles through the consultation, but that patients are projected into a passive role at points where explicit teaching occurs, even if they resist this role allocation (Monrouxe, Rees & Bradley, 2009).

Rees, Ajjawi & Monrouxe (2013) show how junior doctors are socialized into taking on an active role that reinforces the interactional asymmetry where the doctor manages the interaction and the patient plays a more subservient, subsidiary role. Other research explores how doctors construct a passive role for the patient during the bedside consultation as part of the process of modelling patient care to junior doctors, who are learning about their professional roles through the consultation (Monrouxe, Rees & Bradley, 2009). This research shows that participants take on a range of roles in the consultation from ‘audience, nonperson and prop’ (the patient) and actor, director, nonperson, audience and others. Treating the patient like a ‘prop’ is reminiscent of the practice of talking about the patient and/or his/her symptoms while looking at a computer screen during the consultation, which can be thought of as attending to the disembodied patient (§5.3.6.2).
These roles are distributed to participants in the BTE in ways that manage their involvement respectively through the consultation. This is often done using ‘backstage’ and ‘frontstage’ interactional platforms (Goffman, 1990), which act as resources to include or exclude participants, particularly patients. Such inclusion or exclusion is accomplished by such means as allocating the roles for the consultation or activity mentioned above (‘performing’ or ‘audience’ roles) to different participants (e.g. patients), with the front/backstage nature of the interaction marked by high or low speech volume.

Doctors can also sideline patients and limit their involvement in discussion by asking polar “yes/no and wh-questions” (Wang, 2006; Goffman, 1990:927), and also use embodied and other means by to include or exclude patients during such activities as physical examinations. These embodied and other resources include gaze shift (away from the patient) as well as the use of technical terminology or complex wording that patients may have difficulty understanding (Elsey, Challinor & Monrouxe, 2017).

Investigators have also described how participants use verbal means (e.g. questions, orders, advice, pronouns and ‘medical/belief talk’, interruption, laughter) and embodied (e.g. proxemics, namely location occupied in the space), as well as possession and the use of equipment such as stethoscopes, to construct and maintain power asymmetries (Rees, Ajjawi & Monrouxe, 2013; Rees & Monrouxe, 2010). Analysis in this research deploys thematic framework and discourse analysis.

The allocation of passive roles to patients (and others) as described in the research above can be interpreted in different ways. It may be seen to have the effect of dehumanizing them by shifting the frame from treating to teaching, thereby transforming the patient from the focus of attention as a suffering or sick individual and an active participant in the consultation, to an object of analysis. Conversely, however, in conducting a discussion of the patient’s symptoms in their presence could also be construed as openness and giving the patient an opportunity to hear what is being said about them. In either case, this kind of practice highlights the complexity of
the tasks that must be accomplished at the bedside and shows how this complexity is sometimes displayed in interactional strategies participants choose.

2.2.8 Research orientation of prior studies

Much research into hospital interaction is oriented to the doctor’s (rather than the patient’s, students’ or other attendees’) perspective. This may reflect the relatively under-addressed nature of the perspective of the patient (and other participants who are not doctors) and how this may play out in interaction during the bedside consultation. What part do patients play in the shaping and conduct of the consultation? How do they respond to the passive roles sometimes allocated to them by their doctors, and (how) do they resist these roles? These are some of the issues this research aims to address.

From the doctor’s perspective the ward round can be experienced as clinically efficient and effective (Hodgson, Jamal & Gayathri, 2005), but at the same time possibly routine to the point that supervising doctors may find it difficult to fully engage with patients or junior doctors, particularly late in the round when they are tired, or when they are under pressure to discharge patients to free up beds (Launer, 2013; Cohn, 2014; Manias, Rixon, Williams, Liew & Braaf, 2015). There is also evidence showing that consultations become shorter as the ward round progresses (Creamer, Dahl, Perumal, Tan & Koea, 2010).

Research that addresses teaching during the bedside consultation, again chiefly from the doctors’ perspective, includes studies focused on clinical or administrative skills, for example about disease assessment or management (Ende, Pomerantz & Erikson, 1995; O’Hare, 2008; Bradfield, 2010; Sweet & Wilson, 2011; Soliman et al., 2013; Goitein & James, 2016), and also participation patterns between doctors and nurses includes accounts of the engagement with patients as well as doctors (Monrouxe, Rees & Bradley, 2009; Desai, Caldwell, & Herring, 2011; Weber et al., 2007), but with patients presented as passive recipients of ‘communicative tokens’ (Weber et al., 2007).
The experience of the bedside consultation can be intimidating for the patient (Geisler, 1991; Hodgson, Jamal & Gayathri, 2005; O’Hare, 2008). However, in general, the patient remains an implied presence in much research (Denniston, Molloy & Rees, 2018; Walton et al., 2016) in the sense referred to above of focus on issues concerning doctors’ (rather than patients’) actions, beliefs or behaviour. As a result, there remains relatively little understanding of the patient’s role in the interaction of the consultation.

While the attention and feedback about his or her progress may be welcome, this may be balanced by discomfort for the patient due to a relative lack of privacy (in a shared ward), being surrounded by a group of strangers (the medical team) during the bedside consultation, the possibility of difficulty understanding what is being talked about, either because of problems hearing, understanding or not being given enough relevant information, or feeling that he/she is being squeezed into a crowded schedule by the doctors (O’Hare, 2008; Launer, 2013). The fact that the exact timing of the bedside consultation is not specified to the patient means that the medical team arrives at the bedside without warning at a moment that may be inconvenient or awkward to the patient, leaving him or her feeling uncomfortable or embarrassed (Cohn, 2014).

### 2.3 Interaction in community healthcare settings

There is a broad range of research focused on consultations in non-hospital clinical settings, a range of which is outlined in this section as background to the current research. Of particular relevance to this study are those investigations investigating the organization of the consultation and how its clinical goals are accomplished through the activities that participants undertake; how asymmetry between participants plays out, and can be challenged, and how delicate moments are managed.

Issues addressed in the existing body of research include: how patients initiate actions and doctors respond; how authority and control are distributed in the consultation and how the resulting asymmetry between participants plays out (Maynard, 1991; ten Have, 1991; Roberts, 2000; Pilnick & Dingwall, 2011; Heritage, 2013; Robinson, Tate & Heritage, 2016); how delicate moments are managed in the consultation (Haakana, 2001; Maynard & Hudak, 2008; Beach & Dozier, 2015); how embodied actions and orientations contribute to the consultation; how what goes on in consultations shapes
their distinctive interactional structures (Heritage & Maynard, 2006; Heritage & Clayman, 2010; Robinson, 2003; ten Have, 1989; Byrne & Long, 1976) and how policy and new technologies affect interaction (Pilnick, Hindmarsh & Teas Gill, 2009).

Medical consultations are underpinned by institutional goals to which participants orient. These goals inform the organizational structures which shape the consultation, which participants treat as normative. In other words, the consultation is built with reference to a particular normative structure which may be departed from in pursuit of particular local or individual goals (Robinson, 2003). For example, in primary healthcare, a first consultation (where a patient comes to present symptoms of a new health concern to a G.P.) is organized to accomplish the medical goals of diagnosing the patient’s medical problem and recommending a course of action in response (Pilnick, Hindmarsh & Teas Gill, 2009). In secondary healthcare, for example in a follow-up visit to a specialist surgeon, the consultation is shaped by the goals of reassessing the patient’s problem and proposing next steps (e.g. in terms of surgical treatment or care post-surgery) and the organization of the consultation is structured to reflect and accomplish those goals (White, 2011).

The consultation is organized to achieve these goals through structural phases, that comprise activities built up of sequences of action, which in turn are constructed using turns at talk that also generally incorporate embodied action (Heritage & Maynard, 2006). Participants may also have their own individual goals, which they pursue during the consultation.

2.3.1 Structures of the medical consultation

The interactional structure of the consultation has been chosen as a research topic as a means of discovering how this aspect of the encounter shapes patient engagement (Robinson, 2003) to “what actually occurs in consultations” (White, 2011:4).

Structures of the consultation are a central focus of this study (§2.1), and structures of interaction are also central concerns of CA. These and other key concepts in CA are discussed in Chapter 3 (§3.2). In this section, brief summaries of action, (also discussed in §3.2.2.1), activity (also discussed in §3.2.2.6) and overall structural
organization (also discussed in §3.2.2.8) are presented in preparation for discussion of different types of medical visit (§2.3.2) and models of the structures of the medical visit (§2.3.3).

The notion that culturally-based patterns of interaction are the basis for mutually comprehensible communication among community members is integral to the CA paradigm, and these are discussed in more detail in §3.2.2. These patterns are considered to consist of the organization of particular practices that community members are socialized to recognize from birth, and which are consequently considered to be ‘normative’. These patterns are also considered to be independent of personal characteristics such as gender, age or psychological or other social status or condition. In fact, CA holds that it is by the use of these normative patterns that such ‘external’ characteristics are expressed (Heritage & Clayman, 2010). The following conceptualization of structures of interaction that are central in CA are discussed in more detail in §3.2.

The concept of action is the very basis of the CA model of interaction (see also §3.2.2). It is regarded as the ‘building block’ of interaction, which derives its meaning for participants in conversation from its design and from its location in a sequence of talk and/or other action (e.g. ask a question or answer a question). An activity (see also §3.2.2.6) is a sequence of actions that are organized to achieve a particular goal or task (e.g. perform an introduction).

Overall structural organization (see also §3.2.2.8) has been described as a “framework of coherence” (Robinson, 2014:260), and it is less commonly investigated in medical communication research than particular practices that occur in medical interactions or activities or other components or aspects of the encounters. When overall structural organization is investigated it is most commonly investigated with reference to larger units of interaction, such as entire interactional events, rather than smaller units that occur within the larger ones (for example the activity of opening – but see Pillet-Shore, 2008, and Robinson, 2014).
The overall structural organization of the medical consultation as an entire episode of interaction has been investigated and described in the literature, mostly in the context of the acute primary care setting (Byrne & Long, 1976; ten Have, 1987; 1989, 2001; Waitzkin, 1991; Robinson, 2003; Pilnick & Hindmarsh, 2009; Heritage & Clayman, 2010; Heritage & Maynard, 2006) and to a lesser extent, also in the context of the secondary healthcare setting, such as a specialist surgeon clinic (White, 2011), and the genetic counselling clinic (Paul, 2015). Evidence of participants’ orientation to a normative overall organizational structure for the consultation includes: patients’ orientation to floor ownership during problem presentation (Heritage & Clayman, 2010); patients’ orientation to pending loss of floor during transition to history-taking (Robinson & Heritage, 2005); and patients recurrently treating diagnosis as a prelude to treatment recommendation and/or ordering of further tests.

2.3.2 Types of medical visits

There are three key types of medical consultation or visit types in outpatient or community settings. These are: the first visit (new complaint), the follow-up visit and the check-up or ‘well visit’ (for example an annual medical check-up when there are no known medical issues to prompt the visit). Each of these types of consultation has different aims, and is informed by a different set of assumptions, which in turn is reflected in its organizational structures. However, most models of the consultation to date have been based on the first visit (Byrne & Long, 1976; ten Have, 1987; 1989, 2001; Waitzkin, 1991; Robinson, 2003; Pilnick & Hindmarsh, 2009; Heritage & Clayman, 2010) with less known about the organization of the follow-up (but see White, 2011; Paul, 2015) or well visit.

2.3.3 Models of the medical consultation

There are different ways of conceptualizing and describing the medical consultation, that CA and other medical communication researchers have chosen, however they all include a series of activities, arranged in a particular sequence. Some scholars include a broad framework to contain the activities and others do not. In this section I attempt to summarise these approaches, which I do not see as being necessarily opposed.
The term consultation ‘phase’ is used in a similar way as ‘stage’, and it was used by the early medical communication researchers Byrne and Long (1976) to describe the way acute medical consultations were broken up into stages when different clinical tasks were performed (Heritage & Clayman, 2010).

Within the CA paradigm, the focus is on action and what gets done in and through talk. In this context, investigations of how medical (and other) interactions are organized at a range of structural levels provide insight into the organization of this communicative work. Such structural investigations can involve examining organizational structure from the level of an action (e.g. a greeting) to an action sequence (e.g. question/answer sequence) to activity (e.g. perform a physical examination of the patient) to consultation phase (e.g. the consultation opening section) to entire occasion of interaction (e.g. a conversation). Each of these components has its own internal organizational structure that makes it recognizable in interaction to participants, and to which they orient as they co-construct it (Robinson, 2014; Heritage & Clayman, 2010).

This internal structure of the consultation (or other interaction) can be understood as being an overall structural organization which participants recognize and refer to. Within this organization, participants arrange structurally lower order components sequentially, in a particular normative order, and where the relevance of a new component depends on the previous component having been completed. A normative interactional order is a culturally determined framework for a particular type of activity or occasion that participants recognize and refer to in constructing it (Robinson, 2014). Because participants construct its components they need not necessarily occur in exactly the same order every time, but often enough that participants treat it as being routine (Heritage & Clayman, 2010; Heritage & Sorjonen, 1994).

Two key understandings underpin models of the medical consultation structure in communication research. The first understanding is that the consultation is shaped by a sequence of phases during which particular tasks (or activities) are undertaken. Each phase may contain one or more tasks or activities (Byrne & Long, 1976).
The second conception is of the consultation structure being shaped by its constituent activities. In this kind of model, each activity constitutes a complete structural component of the consultation. With both conceptions, there is a normative organizational order that phases or activities occur in, however researchers using each approach acknowledge some degree of sequential variation.

In devising written and schematic representations of consultation structure, some researchers use phase structures, which focus on the higher order organization of the event and contain normatively ordered segments, or phases, echoing the structure of less constrained non-institutional talk (Heritage & Clayman, 2010; Byrne & Long, 1976). Other models are activity-based, showing a normative arrangement of key consultation activities (Robinson, 2003; Pilnick & Hindmarsh, 2009, White, 2011; Paul, 2015). In other words, the structure of the medical consultation has been described in two different ways: as organized through sequentially organized stages (or phases) during each of which certain tasks (or activities) must be completed, or simply as a series of activities that are organized in a particular normative sequence.

Table 2-1 below shows models devised by different researchers to conceptualize the organization of the medical consultation across a range of clinical contexts (following Paul, 2015). All these models represent outpatient or community consultations, and all but White (2011)’s and Paul (2015)’s models represent the organization of a first visit.
Table 2-1  Medical consultation visit structures

Note: green text indicates follow-up visits

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Key:
Black text indicates data is primary healthcare (GP) first visits (i.e. No diagnosis has been made).
Green text indicates data is secondary healthcare (specialist) visits (therefore follow-up visits in terms of the diagnosis having previously been made).
Purple text indicates data includes a range of different consultation types.
Heritage and Clayman (2010:105)’s consultation model describes the first visit in a primary healthcare (GP) setting, while White (2011)’s model is of the secondary healthcare surgeon’s visit. The patients in White’s study had been referred to the surgeon, so although their visits to the surgeon may be their first, a diagnosis had already been made, so that in that sense the visits could be classified as follow-up visits.

White (2011)’s model is therefore a conceptualization of the overall structural organization of the follow-up visit, in terms of the activities that participants treat as normative. Her model is based on the earlier activity-based model devised by Robinson (2003), who draws on primary care visits and he describes the visit as a whole as “a large-scale structure (or project) of interaction” (Robinson, 2003:454).

Robinson (2003)’s model of the first consultation also represents the structure of the consultation in terms of interdependent activities. It shows the normative progression of the interaction as well their connection in terms of the range of their possible relevancies. In other words, Activity 1 potentially makes all the following activities relevant but not necessarily all of them. The activities that do occur must occur in the order shown, because for example, no treatment recommendation can be made before a diagnosis, and a diagnosis requires the collection of information through verbal or physical examination. However, it is possible that no definitive diagnosis can be made on the basis of the information collected on this first occasion, and conversely if it turns out that a diagnosis is made that requires no treatment, then no treatment recommendation is relevant.

This model consequently shows that there is a range of possible compositions of the consultation based on a normative structure but responsive to the local context. However, this model ignores the activities that precede and follow Activities 1 and 4, namely opening and closing. This model therefore concentrates on the main medical business of the consultation rather than on the consultation as a whole event.

Byrne and Long (1976) pioneered the modelling of medical consultations and presented their conceptualization as a series of six phases. Their work laid the
foundation for a vast body of medical communication research some of which is reviewed in this chapter. Byrne and Long used a large data set based on a range of different clinical settings to arrive at their model.

Heritage and Clayman (2010) frame their model as being organized as a series of normatively sequenced activities within the framework of a series of three phases. This is the approach taken in this study.

A larger body of work investigates the structure of the consultation at a lower organizational level. This research includes investigation of different activities that form part of the medical consultation, again mostly in primary healthcare settings. These activities include consultation openings (Robinson, 2014; 1998), closings (West, 2006), history-taking (Boyd & Heritage, 2006), soliciting problem presentation (Robinson, 2006; Heritage & Clayman, 2010), diagnosis delivery, and treatment recommendation (Stivers, 2006).

It remains the case, however, even with the very substantial size of the research literature about different aspects of medical interaction in non-hospital (and hospital) settings, relatively little is devoted to the study of overall structural organization (Robinson, 2014). This supports the value of the chosen focus of this study, with relation to the bedside consultation. In addition, investigating the overall structural organization of bedside consultations more fully than has previously been done can be seen as being a crucial prerequisite of examination of specific activities and other interactional phenomena.

It is also possible that the fact that participants in interaction seem to orient to ‘preliminaries’ before the commencement of ‘business’ (Robinson, 1998), as well as there being a need to disengage from ‘business’ towards the closing (Heath, 1986; West, 2006), may suggest that participants themselves orient to ‘business’ being a distinctive package of work (albeit often with different components) within the encounter.
2.3.4 The doctor-patient relationship

How can the relationship between doctors and patients in the consultation be understood, and how does this shape the interaction and organization of their encounter?

The relationship between doctors and patients is characterized by asymmetry at different levels, in keeping with its institutional foundation (Pilnick & Dingwall, 2011; Robinson, 2001; Roberts, 2000; ten Have, 1991; Perakyla, 1998). This asymmetry is constructed jointly by participants in and through their interaction, turn by turn, and it applies to the participants’ respective rights to the floor, access to specialist knowledge and associated rights to manage the agenda. Doctors and patients assume institutionally relevant roles of expert and lay person. The doctor-patient relationship is the focal relationship in medical encounters in most clinical settings.

Doctors wield medical authority in the consultation, and patients orient to them doing so. Doctors exercise this authority through interaction in the consultation in a range of different ways. They pursue a medical agenda which is characterized at different points (such as when taking a medical history) by such means as initiating question sequences (Heritage & Clayman, 2010; Boyd & Heritage, 2006; Robinson, 2001), thereby directing the course of the interaction by restricting the range of relevant types of response available to patients. Doctors also initiate new activities in the consultation, often using questions sequences, and in so doing manage the agenda of the encounter.

Patients generally orient to this asymmetrical relationship by acquiescing to doctors’ exercise of the interactional rights outlined above. Patients also display an orientation to being obliged in some situations (such as first visits to the G.P.) to having to justify their decision to seek medical help (Heritage & Clayman, 2010), thereby claiming the implied status and associated privileges of the sick role (Pilnick & Dingwall, 2011). Mikesell (2013) observes that much of the literature focused on this relationship is constructed from the perspective of the doctor rather than the patient. Mikesell (2013) reviews the literature about this relationship, from the patient’s perspective.
The asymmetry of knowledge evident in medical discourse has been argued to contribute to the accomplishment of institutional goals and intrinsic to the relationship between the roles of doctor and patient (Pilnick & Dingwall, 2011). In this sense, the doctor-patient relationship has parallels with the relationship between teacher and student in classroom teaching situations (Macbeth, 2004) as well as with participants in other institutional encounters (Drew & Heritage, 1992; see discussion of institutional interaction in §2.2.2).

In the context of this discussion of the doctor-patient relationship, and of the asymmetry which is the focus of much discussion about the doctor-patient relationship, an important concept to understand is that of agency. ‘Agency’ conceptualizes people’s “ability to influence events in their social worlds according to their preferences, needs and desires” (Koenig, 2011:1107). Speakers can achieve agency in and through emergent interaction by shifting their orientations. In medical consultations, patients have resources through which they can exercise agency in the encounter, even in the face of its multifaceted asymmetry (Maynard, 1991; Pilnick & Dingwall, 2011). These resources include strategically initiating and responding to actions (Koenig, 2011; Teas Gill, 2005; Kravitz, Bell, Azari, Kelly-Reif, Krupat, & Thom, 2003; Costello & Roberts, 2001; Stivers, 2005a, 2005b). Participants in medical encounters have a multitude of resources available to them to be used to exercise agency, including turn design, and response to preference built into prior turns.

2.3.5 Dilemmas in the medical consultation

The medical consultation has been shown to recurrently throw up challenges and dilemmas for participants. Doctors and patients (as well as other consultation participants) must resolve particular interactional dilemmas at different points in the consultation (Heritage & Clayman, 2010; Teas Gill & Roberts, 2014). ‘Medical CA’ research provides insight into the nature of these dilemmas in primary healthcare settings, and how doctors and patients act to resolve them. However, little is known about what dilemmas characterize the bedside consultation. How similar are they to the issues that have been described in relation to other types of medical consultation?
How might they reflect distinctive issues that are relevant for inpatients? How do participants in the bedside consultation manage these dilemmas?

Various challenges of this kind confront patients. Several interactional dilemmas described in relation to primary healthcare settings concern issues of face. For example, patients act to avoid appearing frivolous, disingenuous or unjustifiably anxious by highlighting his/her symptoms; how to balance concern and trouble-resistance.

In primary healthcare consultations, patients face the challenge of establishing their legitimacy as patients during initial visits (which focus on new medical concerns) and to display an attitude towards their condition that is aware but not overly anxious or concerned Heritage & Robinson, 2006; Teas Gill & Roberts, 2014).

The patient must also find how to achieve a desired and appropriate level of involvement in consideration of the medical problem presented by his/her symptoms, while simultaneously deferring to and showing respect for the clinical skills and experience of the doctor. Patients may, for example, act to participate in the diagnostic process either before or after the doctor has delivered a diagnosis (Gill, 1998; Perakyla, 2002; Gill & Maynard, 2006).

The patient may offer his or her ‘candidate explanation’ during the process of the collecting evidence and considering the problem the symptoms may represent. Such explanations may anticipate (or follow) the doctor’s diagnosis, which may or may not coincide with the patient’s own. The dilemma for the patient that the candidate explanation conveys is the problem of how to play an active part in an analytic process where he or she (the patient) is an acknowledged lay participant seeking professional advice and that the consultation has a structure that accommodates and reflects the needs of the diagnostic process (Teas Gill & Roberts, 2014).

The dilemmas described above regarding accounting for their visit in a primary care setting, are dilemmas of face, however these may also be relevant in other clinical settings (including inpatient settings) to different degrees. For example, patients in an
outpatient setting generally display a wish to present themselves as reasonable, independent and morally responsible rather than self-indulgent (and thereby implicitly morally deficient) in seeking medical attention for their health concerns (Halkowski, 2006; Heritage & Robinson, 2006). They use interactional means such as how they talk about reaching the decision to seek medical advice, to achieve this (Halkowski, 2006; Heritage & Robinson, 2006).

An additional challenge for the patient in a new problem consultation can be how to save face if the problem about which he or she came to see the doctor about, turns out to be trivial or not a problem at all (Teas Gill & Roberts, 2014). This issue of face management is also relevant at the bedside but to my knowledge it has not been described in that clinical context. That suggests that little is known about how this is manifested in terms of the particular face issues patients face or the means they use to deal with them. This is an issue this thesis is able to clarify to some extent, and it is touched on in results chapters.

While patients must find ways to present the ‘doctorability’ of their condition (as described above), doctors must at the same time must find ways to balance the competing needs to display caring attitudes to their patients while maintaining professional detachment (Heritage & Clayman 2010).

In the face of the passive resistance that the strategies described above represent, doctors are able to pursue the normative, preferred response from the patient (acceptance) by expanding the recommendation by providing additional information about the recommendation or clarifying possible ambiguity inherent in the recommendation (Koenig, 2011). Koenig (2011) argues that by withholding acceptance of treatment recommendations, patients are exercising agency in a way which constitutes positive action. A cycle of recommendation, refusal or passive resistance as described above, followed by an expanded proposal that is effectively a ‘second offer’ constitutes a negotiation, and this is something that may extend beyond the treatment proposals discussed in this research.

Both patients and doctors both orient to the acceptance of treatment recommendations as being preferred during the treatment recommendation activity of the consultation.
Furthermore, it is the expected, normative outcome (Costello & Roberts, 2001; Stivers 2005a, 2005b, 2006). However, as proposal and acceptance are part of a jointly negotiated process, and acceptance (or refusal) are necessary for completion of the process to be possible. This means that patients have the capacity to refuse and resist treatment recommendations or other proposals (Teas Gill & Roberts 2014). Patient resistance of proposals presented by doctors may be direct, but is often indirect, achieved by such means as withholding acceptance in various ways. These include producing minimal actions of acceptance such as minimal responses (Stivers, 2005b), single head nods and silence in the responsive second position slot (Koenig, 2011). Direct resistance can include the patient asking questions about the recommendation or by outlining reservations about accepting it, as well as producing objections to the proposal (Koenig, 2011).

2.3.6 Managing delicate moments

Delicate moments arise in medical consultations at different times, and participants must find ways to manage them. What kind of delicate issues arise during medical consultations and how are they managed? To date we know relatively little about how the management of delicate moments occurring at the bedside, but more is known about how these occasions play out in other settings.

Delicate moments in the consultation can be framed as times when participants (patients particularly) may have to be seen in an unflattering light, when patients’ and doctors’ agendas or talk are somehow at odds or when patients resist doctors’ suggestions (Haakana, 2001). They can occur in relation to issues in medical consultations and can include end-of-life discussions or discussions about dying (Parry, Land & Seymour, 2014), treatment recommendations, (Bolden & Angel, 2017), discussing adverse experiences (Beach & Dixson, 2001) including ‘psychosocial concerns’ (Beach & Mandelbaum, 2005), also when patients unilaterally raise concerns outside the current medical agenda (see §6.3.5, §4.4.3.3) and challenge doctors’ reassurances and optimistic evaluations (Drew, 2005).

In an example of a delicate situation to be managed in a secondary healthcare setting, Bolden & Angell (2017) describe treatment recommendation practices in the
secondary care setting of the psychiatric clinic, which they distinguish from those in primary healthcare settings (Stivers, 2005, 2006). Psychiatrists organize treatment recommendation in a more elaborate, multi-stage manner so that patients fully endorse and accept doctors’ treatment proposals rather than securing the patient’s simple agreement on the basis of a single turn proposition. This is in order to optimize patient commitment and compliance and manage patient resistance to the suggested regime. Treatment recommendation may not be the delicate issue at the bedside that it can be in community settings, however interactional strategies described in literature such as this that are carefully organized to persuade a possibly reluctant patient to accept propositions that may be better aligned to the doctor’s agenda than to the patient’s agenda. Interactional strategies such as those described in the literature may also have relevance for other, distinctive delicate issues that may arise at the bedside (§6.3.5).

Uncertainty is a potentially sensitive issue often relevant in the medical consultation, and doctors and patients have both been shown to display minimal overt emotion or affect when approaching it. This is similar to and perhaps related to the notion of ‘troubles resistance’ (Jefferson, 1984) where patients display stoicism when faced with bad news (Beach, 2002). When patients in oncology interviews express anxiety by asking questions related to their condition, they do so with minimal emotion or affect. In response doctors have been found to use even less affect (Beach & Dozier, 2015). However, there are other ways patients may manage uncertainty, such as by the use of laughter and joking, and this strategy for managing uncertainty and other delicate issues during medical consultations is discussed below.

2.3.7 Interactional practices in the consultation

Among the multitude of interactional practices evident in medical discourse, in this section two are discussed: small talk and online commentary. Both are deployed during medical consultations to optimize patient confidence in different ways during the consultation. Although these practices have been investigated in relation to consultations in primary and secondary healthcare settings, little work has been conducted examining their role at the bedside.
Small talk is a resource used to help establish rapport and minimize discomfort or distract from otherwise awkward or potentially embarrassing actions during the consultation (Maynard & Hudak, 2008).

‘Online commentary’ (Heritage & Stivers, 1999; Heritage, Stivers, Richardson & Mangione-Smith, 2010) is a practice doctors use to optimize patient understanding during physical examinations and also, in an Emergency Department setting, to facilitate and coordinate medical teamwork by foreshadowing next actions (Heritage, 2017). During the activity of the physical examination, the doctor often tells the patient what he or she is observing and flags what he or she is about to do. This practice has been referred to as ‘online commentary’ (Heritage & Stivers, 1999; Heritage, Stivers, Richardson & Mangione-Smith, 2010). This practice can serve several purposes: in a primary healthcare context, online commentary can foreshadow likely next steps and sets patients’ expectations and may implicitly pressure or encourage the patient to acquiesce to particular forthcoming treatment recommendations (so for example a ‘no problem’ response to the examination may forecast a ‘no antibiotic treatment’ recommendation). In an Emergency Room consultation, the online commentary may also be used as a means for creating common ground and understanding about the patient’s condition among members of an attending medical team (Heritage, 2017).

‘Small talk’ (or ‘phatic communion’ – Malinowski, 1923) is talk that is light hearted, “minor, informal, unimportant” (Coupland, 2000:1) and used to divert attention away from an ongoing, just prior or forthcoming activity. Small talk can occur at the boundaries of actions at different points of a conversation, particularly during openings and closings, but also during the middle of conversations. In an institutional setting, including the medical consultation, small talk can shift the focus of attention away from ‘work talk’ (or action) that may be sensitive in character, to ‘non-work talk’ that is more neutral in character. Maynard & Hudak (2008) show how in primary and secondary healthcare settings small talk may be used at the same time as a clinical activity (which they call ‘disattentiveness-in-simultaneity’), or as a response to a prior action (‘disattentiveness-in-sequence’). Doctors may use small talk to shift attention from anxiety or other concerns patients display that may be unrelated to the main
complaint. Patients may initiate small talk to divert attention from delicate situations such as dis-preferred treatment recommendations, or intrusive activities, such as physical examinations (Maynard & Hudak, 2008; Hudak & Maynard, 2007).

Laughter, joking and the invocation of humour are, collectively, a relatively well-documented example of a strategy used for managing awkward or uncomfortable moments in medical (and other) interactions. The following part of this section outlines ways laughter and joking can work to achieve this. As with other parts of the literature, most of what we know about how laughter works at delicate moments in the consultation concerns encounters occurring in non-inpatient settings. Laughter and humour are important resources available to and used by participants in medical consultations of many kinds to manage delicate, poignant and otherwise sensitive issues and moments (Beach & Pickett, 2017).

Laughter can be either affiliatory or hostile, constructed in either collaborative or competitive ‘play frames’ for purposes described by Boxer and Conte-Cortes (1997) as ‘bonding or biting’. As an affiliatory action, laughing can allow people to act together and affirm a common stance or perspective, with participants laughing with each other. As a hostile or disaffiliatory action, laughing can be associated with teasing, where an invitation to laugh is an invitation to laugh at a person who is present (see Section 5.3.3.1). There is a sense, therefore, in which laughing together displays interactional symmetry, alignment and affiliation (Haakana, 2001; Jefferson, Schegloff & Sacks, 1987).

Within a normative environment where one-at-a-time interaction is predominant, shared laughter constitutes a ratified contravention of the rules. Indeed, initiating laughter may in some circumstances activate a related normative order where laughter in response becomes relevant and to withhold it is troublesome (Sacks, 1992; Haakana, 2002). Shared laughter is also found as a sequence-closing strategy (Holt, 2010, 2016). Laughter provides a means to manage delicate moments in a medical consultation by modifying potentially face-threatening or otherwise problematic action (Jefferson, 1974; Haakana, 2001; Beach & Prickett, 2017). Laughter and smiling are used strategically and in organized ways in interaction (Haakana, 2010). Such delicate
matters can include times when a participant (often a patient) uses laughter to project ‘not caring’ or ‘not being engaged with what’s going on here and now’ or ‘not taking things too seriously’ ahead of a moment when he or she may be projected in an unfavourable way (Jefferson, 1979; Haakana, 2001, 2002). For example, while patients work to justify their decision to seek medical treatment (Teas Gill, 1998; Heritage & Clayman, 2010) or how they work to project a stance of stoicism or troubles resistance in the face of bad news (Jefferson, 1988).

2.3.8 Consultation duration

This thesis aims to describe the bedside consultation and show how it is distinct from and unique compared with medical consultations in other clinical settings. The consultation duration is an ethnographic feature, but when combined with an account of what happens during the consultation, this information contributes to our understanding of its character. This understanding is enhanced if there is information about the duration of its component parts. For example, how long does it take for the medical team at the bedside to see their patients, assess the patients’ condition and complete the rest of their work? How much time do patients have to see their doctor and discuss matters of concern, receive information or hear doctors’ views about their (the patients’) condition?

It is relevant to this investigation to know something about the consultation duration because this dimension feeds into the structural organization of the consultation, which may be tightly constrained, as may the time available to accomplish its work. There is little research documenting the duration of hospital bedside consultations. However, a 2010 New Zealand study conducted at Auckland City Hospital shows that its duration varies between averages of 1:50 minutes and 2:30 minutes, depending on the kind of ward in which they occur. Consultations occurring in centrally located wards (general surgical inpatient wards and ‘acute’ wards located close to the Emergency Department, where newly admitted emergency patients were accommodated) are shorter than those occurring in wards located further away, so-called ‘outlier’ wards. Rees & Monrouxe (2010) also document the duration of 27 bedside teaching encounters in a UK hospital and find that it varies between nine and 22 minutes, with an average of 17 minutes per consultation.
The duration of the complete individual ward round visit has been reported to range from 15 minutes (or more) to five minutes per visit (Cohn, 2014; Creamer, Dahl, Perumal, Tan & Koea, 2010; Bradfield, 2010; Veigel, Schmidt, Kollmar et al., 2012), with the time spent at the bedside varying from just under three minutes to just under six minutes (Creamer et al., 2010). Creamer et al (2010) reports that the bedside consultation in New Zealand hospital averages 2 minutes, 57 seconds. Recommendations have been made that the duration of the total ward round consultation (including the components that occur away from the bedside) should be 15 minutes (Creamer et al., 2010; Kithri, 2012). Deveugele et al (2002) reported an average duration of 10.7 minutes (SD 6.7) in general practice consultations in six European countries. Roter and Hall (2006:113) report European general practice consultations in their data range from 7 to 16 minutes, and US consultations average 17 minutes’ duration.

2.3.9 Multi-modal elements of the consultation

What do we know about the role played by multi-modal elements in the medical consultation? In this section a range of findings about this issue are presented.

There is a substantial literature about particular embodied modalities of communication such as gesture and gaze and less on how different modalities are used together. It is beyond the scope of this study to examine this literature in detail and it is not a key focus of the study. However, face-to-face interaction is inevitably multi-modal and communicative modalities other than speech are integral to interaction during the bedside consultation. For this reason, in this section, a survey of selected literature concerning what is known about multi-modal interaction in general and in medical settings in particular is presented. Much remains unknown about this aspect of interaction in the context of the bedside consultation and the current study aims to contribute to filling this gap.

Much of what we know about medical interaction is based on analyses that focus mostly or exclusively on speech. There is, however a substantial literature focused on embodied interaction in healthcare, which adds depth to what we know about how
different modalities interact during medical consultations, particularly concerning gaze and hand and arm gesture. Space limitations makes a detailed survey of the larger literature of non-verbal interaction impossible, however it is briefly outlined in this section because of its relevance at the bedside.

Much of the focus of research into institutional discourse (including medical discourse) is on speech, and on actions accomplished by and through speech (Atkinson & Heath, 1981; Heritage & Maynard, 2006; Stivers, 2006; Robinson, 2006; Boyd & Heritage, 2006; West, 2006). However, it is also widely accepted that meaning making through face-to-face co-present interaction is multimodal, and that embodied and other semiotic dimensions are invariably integrated with speech to accomplish social action (Goodwin, 2000; Streeck, Goodwin & LeBaron, 2011; Heath & Luff, 2014; Rossano, 2014; Stivers & Rossano, 2012; Rossano, Brown & Levinson, 2009; Mondada, 2011; Zemel, Koschmann & LeBaron, 2011; Schegloff, 2007; Kendon, 2000; 2004; Goldin-Meadow, 2005; McNeill, 1992; Heath, 1986; Goodwin, 1986; Goodwin & Goodwin, 1996; Green, 2009, 2014). Indeed, the connection between different communicative modalities has been shown to apply not only in face-to-face co-present encounters but also to those where interlocutors do not occupy the same physical space.

In medical interaction, the interplay of different modalities in accomplishing different kinds of activities and actions has also been documented with regard to such issues as initiating activities using multiple embodied communicative modes (Robinson, 1998), accomplishing transition from one activity to another (Robinson & Stivers, 2001), establishing, maintaining and breaking engagement during the consultation (Heath, 1986), coordinating actions during surgery (Mondada, 2011; Hindmarsh & Pilnick, 2007), and testing trainee surgeons’ understanding during surgeries (Zemel, Koschmann & LeBaron, 2011). The work of incorporating embodied elements into accounts of interaction in different medical contexts is growing, in fact Heath & Luff (2014:283) remark that: ”We have seen a flourishing of conversation analytic studies of social interaction that have increasingly demonstrated how the production and intelligibility of social action in face-to-face or co-present gatherings is accomplished by virtue of a complex range of resources – the spoken, the bodily and the material”.

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However, within the growing body of work addressing the role embodied action plays in interaction, a seldom mentioned semiotic resource that has been shown to be relevant in institutional settings, including the hospital (Jenkins, 2014) is appearance and dress. This is an area that is little understood, possibly taken for granted and is thereby invisible in our efforts to understand how face-to-face (and other) interaction works. Yet appearance, dress and physical presentation may yet turn out to be important elements of meaning-making during medical consultations (as well as other kinds of institutional and non-institutional encounters). As such, this constitutes an intriguing and possibly important gap in the literature to date. It is a gap this study aims to help fill.

Everyday experience and participation in the social world shows us that appearance, including the clothing people choose to wear or are required to wear in different situations, plays an important role in identity formation and expression. This phenomenon underwrites whole economic sectors in western society, such as the fashion industry to name one obvious example.

The role played by appearance and presentation in studies of interaction is minimal, indeed “language and clothing are rarely, if ever, discussed together in the same conceptual space” (Keblusek, Giles & Mass (2017). However, clothing along with facial recognition, has been shown to play an important role in people’s understanding of who they are, and who they are with (Ferstl, Bulthoff & de la Rosa (2017).

In the workplace, clothing has also been shown to be an important source of symbolic power and authority, for examples through the use of uniforms to mark institutional rank and role. In the hospital setting, clothing norms have been argued to influence how employees dress. In orienting to institutional norms regarding dress, members of hospital communities thereby display cultural and economic capital in the workplace and act as a subtle but powerful means of displaying and exerting control during interaction (Jenkins, 2014). Clothing and physical presentation consequently act as semiotic resources for participants in medical interaction, as an embodied communicative channel.
Clothing as an embodied marker of place in hospital hierarchy is explored by Jenkins (2014). Jenkins focuses on the capacity of clothing to embody and maintain institutional asymmetry within hospital relationships, however unlike other sources of asymmetry, clothing is not explicitly referred to in many if any studies of hospital (and other medical) interaction. Nonetheless, Jenkins argues that clothing expresses and contributes to maintaining asymmetry along institutional lines. This is little discussed in academic study of interaction, but beyond the realm of institutional discourse, in popular culture, clothing is a well-established means for expressing place and identity in a community.

Much remains to learn about how participants combine speech and embodied action during the bedside consultation (and other kinds of institutional interaction) to conduct their work, and this study aims to help fill this notable gap in our knowledge. The interplay between speech and embodied or nonverbal modalities during the consultation is referred to during discussion in all the results chapters (4-7). The role played by clothing as an embodied communicative element is discussed in Chapter 5.

2.4 Summary and next chapter

Building on the range of earlier research findings about different aspects of the practice of healthcare in in a range of clinical contexts, discussed in this chapter, this study investigates how doctors, patients and other participants in the bedside consultation organize and conduct their work by addressing the research questions outlined at the beginning of this chapter (§2.1).

In light of the literature outlined in this chapter, the RQs are re-presented here to reinforce the question underpinning this research: What is the character of the bedside consultation? The RQs seek to address this issue in the following terms:

1. What is the overall structural organization of the bedside consultation?
2. How is the bedside consultation opened?
3. How does the business of the consultation unfold?
4. How is the bedside consultation closed?
The literature contributing to these questions is based on investigations using a variety of different tools and methodologies. A selection of it with relevance to the concerns of this thesis was reviewed in this chapter. The following chapter, Chapter 3, outlines the research design, rationale and methodology for this study, as well as a summary of the analytic research methodology used. It provides a methodological and theoretical context for study findings presented in later chapters (Chapters 4, 5, 6 and 7).
Chapter 3 Method

3.1 Introduction

In this chapter, I provide a detailed explanation of how this study was designed and the overall methodological framework supporting it. The chapter is organized in the following way. A description of the methodological framework for the study (§3.2) precedes discussion of the method (§3.3 - §3.8). This introductory section introduces key concepts of CA since this methodology underpins the thesis (§3.2.2).

Following this introduction, overviews of the data (§3.3), participants (§3.4), data collection (§3.6), software used (§3.7) and analysis (§3.8), and of the ethical parameters framing the data collection and use (§3.5) for this research are presented. The chapter concludes with a summary and a brief outline of the next chapter in the context of the remainder of the thesis (§3.9).

3.2 Methodological framework for this study

This is a qualitative study which aims to shed new light on how the bedside consultation works, and therefore the data analysis is predominantly qualitative, guided by CA-type principles and techniques, given that it has become the preeminent methodology for investigation of medical interaction. Structural descriptions and detailed microanalyses of various interactional activities accordingly comprise the core of the findings reported in chapters 4-7.

The study design includes some quantification, which is discussed in more detail below (§3.8.4). The analysis of ethnographic observations along with the quantitative analysis is intended to complement the study’s primary CA analysis by providing a general background of the institutional context, and also information on the (relative) frequency of selected activities (in this data set only). These supplementary analyses help indicate how the specific structural phases, activities, other structures and practices – analysed in detail using CA – fit into the overall characterization of bedside consultations that I aim to present.
3.2.1 Combining qualitative and quantitative methodologies in CA research

The incorporation of ethnographic and limited quantitative data as described above is increasingly embraced by researchers engaged in what has become known as ‘Applied CA’ (Antaki, 2011). In this new field, CA is used to investigate interaction in institutional settings, including medicine, and where these adjuncts are seen to enhance findings and expand the capacity of CA based research to resolve practical institutional problems and puzzles. These problems include whether and how the use of particular wording (‘some’ vs ‘any’ in consultation closings for example) affects patient response and potentially the outcome of a medical consultation (Candlin, 2011; Heritage & Robinson, 2011; Heritage & Stivers, 2014). The link between ethnographic features of the interaction (such as gender, participant role or interaction duration) and interactional behavior or practices may also be made using such a mixed-methods approach (Heritage & Stivers, 2014).

Frequency counting is “the simplest way to reduce a mass of data” (Roever & Phkiti, 2018:31) that, in common with other types of quantitative analysis ‘reduces’ data to a set of items devoid of reference to context. This illustrates why quantitative analysis is anathema to practitioners of ‘pure’ CA, who aim to discover the relationship between individual items in a data set comprising episodes of interaction and their immediate interactional environment, on a case-by-case basis.

Arguments justifying the incorporation of quantitative procedures into CA interactional research include the observation that CA is actually quite quantitative in character for a qualitative methodology (Stivers, 2015). This is because of its emphasis on collections of phenomena of interest, as well as the reliance by CA scholars on descriptors of frequency or quantity when justifying claims about interactional practices. These descriptors include terms such as ‘massively’, ‘recurrently’, “grossly observable” (Sacks, Schegloff & Jefferson, 1974:696) used when describing and referring to interactional practices. In addition, Stivers (2015) notes that in CA phenomena are categorized, and in this process, assessments are made about what ‘counts’ as a given phenomenon. In addition, quantification is familiar to a wider research audience as a way of making sense of data, particularly in ‘applied’ fields involving institutional interactional settings, such as medicine. Its inclusion in
Qualitative research such as CA-based investigations, is therefore a strategy that may be used to make this kind of research more accessible to a wider audience (Stivers, 2015).

Objections to quantification in CA are outlined by Stivers (2015) and include the fact that the conversion of interactional data to a quantifiable form necessitates its ‘freezing’ in a way that precludes any subsequent analytic reconsideration; codification of interactional phenomena also requires the imposition of “hard boundaries” (Stivers, 2015:13) which is difficult to achieve because of their intrinsic complexity, which codification therefore unavoidably undercuts. The final limitation Stivers mentions is that quantification may be analytically unproductive in CA-based research.

3.2.2 Concepts in Conversation Analysis

CA emphasizes the importance of the immediate, local interactional environment as a central source of context for participants in conversation and other encounters (see §2.2.1). This is evident in, for example, the way turns are designed, rights to the floor are distributed, activities are organized, and actions sequenced. This model of context is ‘bottom up’, whereby participants in conversation construct a sense of ‘where we are and what we are doing’ using selections (and omissions) of a multitude of interactional features, and it contrasts with the idea of context as a ‘top down’ phenomenon, where ‘where we are’ dictates ‘what we do’. The complexities of interactional structures and actions are too complex to detail here except in brief, with particular reference to features that are a focus of this study. More comprehensive recent accounts of ‘the interaction engine’ (Levinson, 2006) can be found in Sidnell (2010), Sidnell & Stivers (2014), Clift (2016), Hutchby & Woofitt (2008) and ten Have (1999).

CA analyses of interaction aim to show how participants evoke context through practices such as those mentioned above by systematically observing how interlocutors organize the interaction at one or more of the action levels of turn taking, overall structure, turn design, and lexical choice. They reveal such context-evoking features as patterns of participation, role allocation, distribution of rights to the floor, access to knowledge and access to institutional and interactional knowhow.
3.2.2.1 Action

Action is the key building block in the CA concept of interaction. It is one of the “the two things from which all else follows” (Schegloff, 2007a:9). The other ‘thing’ Schegloff refers to is sequence, or “a course of action implemented through talk” (Schegloff, 2007a:9).

There are a multitude of actions that people accomplish through talk and embodied action, including: requests, demands, compliments, thanks, greetings, farewells, requests for confirmation, invitations, acceptances, declinations etc. Levinson (2014) distinguishes two facets of action: action formation and action ascription. By making this distinction and conceptualizing two components of action, Levinson highlights the roles of both (or all) parties to an interaction: the speaker (who forms the action in a first part) and the recipient (who ascribes a meaning or significance to the action and forms a response, itself an action).

Face-to-face conversation can be understood as a primary way for people to get things done, socially, and how this is achieved in different ways and in situations through talk is the key focus of CA. Social action is jointly achieved by partners in conversation, hence the term ‘inter-action’ that explicitly refers to the back and forth, or socially distributed nature of accomplishing social action through talk. The way CA conceptualizes the accomplishment of action is by way of turns at talk (or embodied action), a complete turn being defined as being capable of constituting some kind of action (for example a question, or an answer to a question; a request or a compliment etc.). To quote Schegloff (1996a:5):

“Talk is constructed and is attended by its recipients for the action or actions it may be doing” (in Levinson, 2014:103)

Sequence is discussed in §3.2.2.2 below, however because sequence and action are interdependent in conversation, the concept of the adjacency pair, a basic unit of sequential talk, is introduced here. The joint nature of interaction lends itself to a system of linked utterances, where a first turn performs an action and a linked second turn/part displays the respondent’s understanding or attribution of the significance of
the first part (Levinson, 2014), giving rise to the CA concept of adjacency pairs. In an adjacency pair, the first part (for example a question) performs an action that makes a particular type of responsive action or second part (an answer) relevant. The base adjacency pair may be expanded (Schegloff, 2007) but the fact of its occurrence shows how actions tend to occur not only in groups, but in particular kinds of sequences (e.g. question/answer). An adjacency pair is characterized as comprising “two utterances that are:

1. Adjacent.
2. Produced by different speakers.
3. Ordered as a first pair part (FPP) and a second pair part (SPP).
4. Typed, so that a particular first pair part provides for the relevance of a particular second pair part (or some delimited range of seconds; e.g., a complaint can receive a remedy, an expression of agreement, a denial as its second).” (Schegloff & Sacks (1973) cited in Sidnell (2010:64).

The concept of adjacency pairs captures how certain types of turns at talk are grouped together in conversations in a regularized way (e.g. questions and answers) that can become a resource for projecting and negotiating meaning. Basic adjacency pair groupings can be given additional meaning by the incorporation of non-standard prefaces or suffixes, and/or by particular features of turn design. The adjacency pair is thereby a resource for encoding a range of common actions including eliciting and providing information, exchanging greetings or farewells, issuing and responding to invitations or compliments. Examples of different actions, such as making a request and making an offer, are shown in Appendix 7 (Extracts 1A and 2A).

3.2.2.2 Sequence organization

Sequence is a key feature of the CA model of interaction, one of the “Two Things” that characterize it (Clift, 2016) – the other “Thing” being action. The location of an action within a sequence of actions is a fundamental and distinctive part of the CA conception of how meaning is negotiated and shared between participants in interaction (Stivers, 2014). The interactional context is key in CA, such that speakers respond to prior turns, taking note of the degree that the design and delivery of the prior turn conforms to or deviates from normative patterns for the action underway. A
speaker’s responsive turn signals his or her understanding of and perspective on the prior turn in its design and delivery. Following this, the first speaker (or potentially another speaker) produces a turn in response that does the same. In this way interaction is built up of a series of sequences of turns and responsive turns, until the conversation is closed.

Another way the interactional system of conversation is made orderly by certain normative structures above the level of the turn. The adjacency pair, where particular pairs of utterances or actions are sequentially linked in a normative way as first pair parts and second pair parts, is the most fundamental of these. Because of the normative character of these action pairings, the failure of a speaker to provide the mandated second pair part, or even to provide it in an expected amount of time, is meaningful or ‘accountable’. The basic AP sequence may be (and often is) expanded (Schegloff, 2007) either before or after the central AP, or both before and after.

A prominent form of adjacency pair and one that is important in medical discourse (and other institutional interaction) is the question/answer pair. The subject of question sequence design and action is large, and beyond the scope of this study to outline comprehensively. This section presents a brief overview of aspects of question design and action that are particularly relevant to institutional discourse and medical discourse in particular. For more detailed insights into question type, design, function and response, refer to a range of recent studies and papers (Boyd & Heritage, 2006; Stivers & Enfield 2010; Stivers, Enfield & Levinson, 2010; Stivers, 2010; Stivers & Hayashi, 2010; Freed & Ehrlich, 2010; Heritage, 2010; Freed & Ehrlich, 2010; Hayano, 2014; Lee, 2014).

Questions demand answers; that is, a question makes an answer relevant. For this reason, questions generally start new sequences of talk. These sequences can be short, comprising a bare adjacency pair of question/answer (an example is shown in Appendix 7). Alternatively, the sequences questions start can be longer, with expansions extending the initial response and possibly giving rise to further follow-up questions (see example in Appendix 7, Extracts 3A and 4A). Questions have certain structural and/or functional features. Stivers and Enfield (2010) specify in their coding
system that utterances must satisfy one or more of the following criteria: they must have a formal question structure with features such as “lexical, morphological, syntactic or prosodic marking” (Stivers & Enfield, 2010:2).

Three broad categories of question design have been identified and described in the literature (Stivers, 2010) and a coding system devised based on these findings (Stivers & Enfield, 2010). These accounts apply largely to question sequences in English but are to an extent universally applicable across a wider range of languages. Question formats fall into the following categories: polar questions (making ‘yes’ or ‘no’ responses relevant); ‘wh-’ (or ‘content’ or ‘Q’) questions (prefaced by words beginning with ‘wh’ such as ‘what’, ‘who’, ‘when’ but also ‘how’); declarative questions, that is questions that are formatted as statements, but which are marked as questions by a final rise in intonation, or alternative questions, namely those formatted to make the recipient nominate one of two alternatives (Stivers & Enfield, 2010).

Polar questions have been shown to be the dominant type of question used in general conversation in American English (70%), followed by ‘wh-’ questions (27%), with alternative questions a distant third (3%). Polar questions as a category can be subdivided into three sub-types, of which declarative (63%) is the most used, followed by interrogative (31%) and tag questions (6%) (Stivers, 2010).

Questions can perform a range of social actions. They may elicit information, confirmation, initiate repair from the recipient (‘Other Initiation of Repair’), perform an assessment (by seeking agreement with an evaluation e.g. ‘it’s a beautiful day, isn’t it?’), deliver a suggestion, offer or request, serve as a persuasive device (e.g. a ‘rhetorical question’, asking a question without seeking an answer) or making an exclamation (or ‘outloud’ where a question is asked without being directed at anyone in particular, e.g. ‘What can you do?’).

3.2.2.3 Turn taking

Turn taking is “a prominent type of social organization” the presence of which “suggests an economy with turns for something being valued – and with means for allocating them, which affect their relative distribution, as in economies” (Sacks,
Schegloff & Jefferson, 1974:696), such that turns are the building blocks which comprise the ‘currency’ of the communicative economy. Indeed turn-taking has been described as “the core matrix for human social life” (Stivers, Enfield, Brown, Englert, Hayashi, Heinemann, Hoymann, Rossano, de Ruiter, Yoon & Levinson, 2009:10587). The orderly exchange of turns enables sense-making between people in interaction, and the attempt to discover and describe the system by which turn taking is managed in different social circumstances and settings is a foundational objective of CA. In their Simplest Systematics, Sacks et al (1974) laid out a foundational series of observations about how turn taking is organized that formed the basis of later CA research.

The turn-at-talk (henceforth ‘turn’) is consequently a fundamental concept in the CA theoretical and methodological paradigm. An early CA observation was that people in conversation with each other take turns to speak in a similar way that people take turns when playing games and conducting many other co-operative activities. They speak singly, sequentially, one at a time, with little overlap or silence between episodes of talk (Sacks, Schegloff & Jefferson, 1974). The turn is a resource for organizing social activity of many sorts, including conversation, and conversation is therefore a means of achieving social action through talk, arranged sequentially by turns. Sacks et. al. (1974:696) note that turn organization is “locally managed, party-administered, interactionally controlled, and sensitive to recipient design”. A fundamental feature of the orderly structure underpinning conversation is that turns follow each other sequentially and one at a time, with no overlap and with minimal gap in time (Sacks et al., 1974). Early observations of the ‘turn taking machinery’ (Schegloff, 1987:71-72) were that “(1) at least, and no more than, one party speaks at a time in a single conversation; and (2) speaker change recurs”.

A conversational turn is understood to mean the words and other communicative actions undertaken by a participant in conversation at a given point in an episode of interaction. As a basic unit of interaction, the turn-at-talk has been conceptualized as a Turn Construction Unit or TCU (Sacks et al., 1974). This unit can consist of a word, a sentence a phrase, or a clause, and during the time it takes to produce, the speaker has the right to the speaking floor. At the completion of a TCU there is a Transition
Relevance Point (TRP), when it is relevant and possible for speaker (and turn) change to occur. At this point, speaker change may (but does not necessarily) occur.

Participants in conversation are at the minimum a speaker and a recipient, namely one person who produces a turn, the other who is the recipient of that turn. There may be more than two parties to a conversation or other kind of interaction (and there often are more than two participants, including in the interactions in this study), but the minimum is two.

Next speakers can be selected by the current speaker, can self-select or the current speaker can continue speaking. Research suggests that people across cultures orient to this basic set of interactional rules (Dingemanse, Toreirra & Enfield, 2013), which serve as a guide for conversationalists to make sense of and respond to prior turns. If a recipient’s interpretation of a prior turn is such that he or she wishes to comply with any inbuilt demands and constraints encoded in a prior turn, then a preferred response that satisfies the conditions of the set of turn taking rules above is produced. If not, then the recipient can produce a response that varies the ‘default’ turn taking rules in some way, potentially producing ‘trouble’ but, in any case, displaying some degree of challenge or dis-alignment with the prior turn.

A current speaker is in a position to select a next speaker by various means including gaze (Stivers & Rossano, 2010) and thereby impose on him or her the normative obligation of a response. A current speaker can also design the current turn to pressure the recipient to provide a particular type of response (e.g. an answer after a question), and even a response with particular features (Stivers, 2010; Stivers & Enfield, 2010; Heritage & Robinson, 2011). Current speakers in these ways exercise a measure of interactional control.

However, recipients have a range of possible responses (in terms of design and the response’s relationship to normative expectations) available to them that shape the direction of the interaction in at least the next turn. This in turn provides considerable agency to a next speaker (Stivers & Hayashi, 2010; Gardner 2014, 2015; Clayman, 2012). Recipients can depart from the constraints of the prior turn and those of
‘default’ turn taking expectations by delaying response, producing a non-fitted or otherwise not relevant response or beginning a next turn before completion of the prior. They can thereby produce variations that may be treated as accountable and consequently ‘troublesome’ in terms of turn taking norms, such as uncomfortably long pauses or overlapping talk.

The exchange of turns, with its varying adherence to normative rules governing turn taking creates a local interactional context for each interaction and each part of each interaction. In this way interaction created by the exchange of turns can be described as simultaneously context shaping (through the construction of each turn) and context renewing (through the design of each responsive turn) (Heritage, 1984).

The relationship between participants has implications for their rights to manage such interactional dimensions as topic change, and the initiation and termination of activities and actions. For example, in institutional interaction of many kinds, the institutional representative or expert in the relevant institutional domain has the authority to set the agenda of the encounter (Drew & Heritage, 1992). This allocation of authority has clear implications for the way an interaction progresses and who has official control of proceedings. This is true for medical discourse, where generally the doctor exercises this authority and the patient generally complies with the interactional agenda set by the doctor (Drew & Heritage, 1992; Heritage & Maynard, 2006; ten Have, 1999; Roberts, 2000; Perekyla, 2002; West, 2006; Pilnick & Dingwall, 2011).

Turns may be expanded, for example with particular prefaces (Rendle-Short, 2007; Clayman, 2013) and designed in such a way as to implicate the relevance of other particular types of responsive turns (in the adjacency pair sequences which is discussed briefly below and in §3.8) in ways that powerfully shape the character of an interaction.

Prefatory or following features are used to convey additional information about myriad features that speakers use strategically to convey meaning at different levels. For example, the turn beginning is a place where there are possibilities to indicate that the turn may not conform to expected relevancies of its sequential positioning. Clayman
(2013) and Rendle-Short (2007) illustrate this idea by showing how address terms (i.e. people’s names) prefacing responsive turns (e.g. question answers), can express agency by signaling that the turn will be misaligned in terms of action, or dis-preferring in content to the prior turn.

Turns are the building blocks of a myriad of social actions built up co-operatively by participants in interaction, turn by turn. The shaping impact of the normative rules of turn taking articulated in CA means that local context is created within a broader framework of meaning in much the same way that the grammar and vocabulary of a particular language can be organized by speakers in such a way as to generate a myriad of meanings and say an almost infinite number of things.

### 3.2.2.4 Preference

Preference refers to the fact that recipients of first actions almost invariably have a range of possible types of response, which are ‘ranked’ in such a way as to “reflect an institutionalized ranking of alternatives” (Heritage & Atkinson, 1984:53). These alternative options encode different degrees of alignment with the format of the first action (including with the course of action of which the first may be a part), and in this way provide recipients with a resource to display levels of alignment (or disalignment) with that expressed by first speakers (Sidnell, 2010).

This means that actions, for example questions, can be formatted in such a way as to pressure the recipient to provide a particular response or a particular type of response. This is a resource that a speaker can use if he or she prefers that the recipient responds in a certain way, for example a history taking question in a medical consultation may be designed in such a way as to ‘prefer’ a ‘no problem’ response (Heritage & Clayman, 2010).

Turn design incorporates a range of features that elaborate its basic function, for example a question can be designed to project the expectation of a certain (limited) range of relevant responses, including, potentially, a preference from among the range of relevant responses for a particular response (e.g. polar questions designed to ‘prefer’ either a ‘yes’ or ‘no’ answer). For example: ‘You heard from her?’ (Hayashi,
2014:405). Sometimes if a dis-preferred question response is given, the question recipient treats the response as dis-preferred by producing a third part account justifying or explaining the dis-preferred response. Examples of preferred and dispreferred responses (and turns projecting those preferences) are shown in Appendix 7 (Extracts 5A and 6A).

### 3.2.2.5 Repair

Repair is the “organized set of practices through which participants in conversation are able to address and potentially resolve such problems of speaking, hearing or understanding [as when a speaker mistakenly using a wrong word, a recipient cannot hear what a speaker said, or a recipient thinks a prior speaker has made a mistake]” (Sidnell 2010:110).

Recipients in interaction may correct or draw attention to difficulties in understanding or hearing, as well as challenge the stance perceived to have been taken in a prior turn. The source of these difficulties is called the trouble source or repairable, and repair may be an important aspect of the negotiation involved in co-constructing interaction.

There is a hierarchy of preferred ways of doing repair. Self-initiated self-repair (when a speaker corrects his or her own perceived error) is preferred over other-initiated self-repair and other-initiated other-repair (when a participant ‘corrects’ a perceived error made by another). Other initiated self-repair is distinguished by the different identity of the person who makes repair relevant. Examples of repair are shown in Appendix 7 (Extracts 7A and 8A).

### 3.2.2.6 Activity

An activity can be understood, in an interactional context, to be “the work that is achieved across a sequence or series of sequences as a unit or course of action - meaning by this a relatively sustained topically coherent and/or goal-coherent course of action” (Heritage & Sorjonen, 1994:4). It can “vary in size or scope” (Robinson, 2014: 267) and also be seen to have the coherence provided by an overall structural organization that links otherwise disparate elements.
The actions that make up an activity are organized sequentially and although they may be unrelated by topic, they are linked and given coherence by their roles in achieving a larger task. An example of this is the activity that occurs during medical consultations of most types, of history taking or verbal examination. The activity of history taking in this context is typically a series of question sequences, led by the doctor, each focused on an aspect of the patient’s present or past health, illness or symptoms. The foci of these history taking questions may be disparate and unrelated except that they are linked in the service of the doctor forming a diagnosis on the basis of the information contained in the patient’s responses.

An activity is therefore a larger unit of social action than a single action, generally (although not invariably) consisting of a series of actions. For example, the activity of opening a medical consultation may consist of the following series of actions: participants ‘doing becoming co-present’, ‘doing a greeting exchange’, ‘doing exchanging pleasantries’ and ‘doing introducing participants to each other’. An example of an activity is shown in Appendix 7.

3.2.2.7 Structures of conversation

Conversation is organized at different levels by participants to generate meaning (Sidnell & Stivers, 2014; Clift, 2016; Sidnell, 2010). In this section key structural elements of this organization articulated in CA are discussed. These range from the higher level overall structural organization, through lower level procedures of turn-taking, the formation and ascription of action and activity, sequence organization, preference and repair. There are also sections focused on question sequences and discourse markers, two particularly important structural elements of interaction, particularly in medical discourse.

3.2.2.8 Overall structural organization

Overall structural organization (§2.3.1; Chapter 4) is part of the system of what Sacks, Schegloff & Jefferson (1974) conceived of as ‘intersecting machineries’ (Sidnell, 2010:2) that shape social interaction. The term ‘intersecting machineries’ refers to different types of organized practices participants in conversation use to convey and
negotiate meaning through interaction. As the term implies, these practices are unavoidably interconnected, and they often occur in parallel, simultaneously.

Overall structural organization is an ordering mechanism that functions as “an overall ‘map’ of an interaction in terms of its typical ‘phases’ or sections’” (Heritage, 1997:227). As such, it constitutes “a relatively external source of interactional coherence that ‘reaches into’ sequence organization, turn construction and opportunities for participation (Lerner, 1998:7); … ‘external’ relative to more local sources of interactional coherence (Schegloff, 2011), including the organization of sequences of action (Schegloff, 2007).” (Robinson, 2014:258). Overall structural organization has also been referred to as an overall ‘project of activity’ (Jefferson & Lee, 1981; Robinson, 2003) or ‘plan of action’ (Levinson, 2014). Implicit in these terms is the idea that overall structural organization relates to the sequential positioning of activities in relation to each other and to a larger interactional enterprise. The term refers to “any kind of organization which concerns the relative positioning of [units]” (Schegloff, 2007:2).

Overall structural organization has been described as being like a traditional Russian nesting doll in its capacity to order and shape interaction at increasingly subtle levels, and it is one of the integral structural components of interaction (Robinson, 2014). A complete episode of interaction, such as an entire medical consultation, has an overall structural organization (to which participants orient), as do its component phases (such as openings or closings), activity sequences (such as history taking or physical examination in a medical consultation) and actions (such as question or question sequence that forms part of a history taking activity in a medical consultation). Similarly, a complete episode of interaction (such as a bedside consultation) can form part of the overall structural consultation of a larger ‘unit’ of interaction, such as a daily ward round visit, that can in turn form part of a larger body of institutional work such as the provision of care for a group of current inpatients.

Overall structural organization constitutes a broad interactional context that links potentially disparate and unconnected activities sequentially and gives them “coherence as part of a single activity” (Robinson, 2014:260). It is one of two key
complementary sources of context in human interaction, the other being the turn-by-turn local organization of talk. Lower level (turn-by-turn) actions and activities are built sequentially into larger activities that are in turn ordered by participants in turn to accomplish larger complex tasks with reference to the broad template of the overall structural organization.

As mentioned above, underpinning the approach of this study is the understanding that interaction is highly ordered and that actions participants make are understood and responded to by other participants in ways that construct a communicative context for that (and each) interaction. The work of the encounter is achieved by a series of such actions and re-actions performed sequentially. In exploring this process, a number of questions arise. What actions do participants perform? How are they fitted together? How are they grouped? How are groupings of action arranged? How do participants signal when one set of activities is about to end, and another begin? How are boundaries between activities marked? Is there a formal structure that participants refer to and use to guide their construction of the interaction? If so, what does it look like?

In order to unlock the underlying patterning that consultation participants recognize and refer to help shape their interaction (or that they ‘orient’ to), further questions arise, such as: Who initiates actions? What activities do they undertake? In what order? Does the same category of participant always initiate them and if the identity of the initiator changes, does the response to their proposed activity shift correspondingly? Are activities repeated? If so, when and how often are the activities repeated, and under what circumstances? How can we tell that participants ARE orienting to a higher order patterning?

Participants in most interactions orient to a similar overall structural organization at the level of a complete episode of interaction, namely an organization comprising an opening, a closing and something (‘topics’) in between (Sacks, 1992; Schegloff & Sacks, 1973). At every point in the interaction, participants co-construct activities to address particular relevant interactional problems, for example, how to begin a conversation; how to bring a conversation to a close; how to achieve interactional tasks
such as (in a primary healthcare consultation) reaching the point where the doctor can propose a treatment and care plan for a patient who comes to the surgery with a symptom or set of symptoms, based on the results of examination of the patient’s body and account of their symptoms. For this to be possible, doctor and patient jointly conduct a series of activities in a particular sequence for it to be possible to reach a point where the consultation can be brought to a close (Schegloff & Sacks, 1973).

Openings and closings may have characteristics that mark the interaction in which they occur as distinctive, however it is often in the ‘something’ in between that an interaction’s particular social character becomes most strongly evident, distinguishing, for example, the job interview from the family dinner conversation, the court appearance from the dental appointment, and the bedside consultation from the primary care consultation in the GP’s office.

That part of an interaction between its opening and closing sections is important because during this phase actions and activities that participants co-construct accomplish the work that is the principal purpose of the encounter. These activities have been referred to as ‘topics’ that occur between opening and closing (Schegloff & Sacks, 1973). These ‘topics’ overtly embody distinctive tasks involved in ‘doing the work’ of that particular encounter and/or particular type of encounter. It is consequently during the core of the conversation that the overall organizational structure of the interaction becomes particularly relevant and apparent. This is where the broader social context that participants evoke through interaction is particularly evident, and where this wider context can be seen ‘reaching into’ the particular interaction and giving it the character that makes it recognizable as such to its participants.

The term ‘normative’ here refers to actions that “are regulated by social norms (or rules) and in the sense in which they are the object of psychological processes [such as] morally valenced attitudes” (Enfield & Kockelman, 2017:192). Part of the broader social context generated by overall structural organization involves the activation of roles normatively allocated to and assumed by participants, and thereby implicitly defining participants’ relationships with each other for that occasion. This normative
role distribution between participants in interaction determines who participants are to each other for that encounter (Sacks, 1992; Rossano, 2014; Robinson, 2014), regardless of their identities, roles, relationships and responsibilities outside it.

Participants’ acceptance of roles allocated to them for an occasion, along with the rights and responsibilities associated with those roles is evident in how they construct the activities and phases of the encounter. They distribute rights to set agendas between themselves, access rights to specialist knowledge and associated authority to present recommendations between participants is made clear through the conduct of the interaction. This allocation of rights is sometimes defended and enforced if challenged. For example, the right to set agendas is evident in who initiates new activities (such as by asking questions) and who responds. The right of access to relevant expert knowledge at different points of the interaction helps define participant roles and identities for that occasion.

3.2.2.9 Orientation

CA conceptualizes participants in interaction as “knowledgeable agents who actively display for one another (and hence, also, for observers and analysts) their orientation to the relevance of [external as well as local interactional] contexts” (Hutchby & Woofitt, 2008:139). CA argues that participants publicly display their understandings of what is relevant in and through interaction, rather than keeping their understanding of what is relevant, private and not explicitly displayed through their words and actions (Hutchby & Woofitt, 2008:140). CA seeks evidence for how participants “make available for each other (and for the analyst) the relevance of an institutional setting. That proof procedure is found in the observable details of talk-in-interaction.” (Hutchby & Woofitt, 2008:140).

‘Orientation’ by participants in interaction consists, therefore, of the choices they make about what interactional practices available from the full range of possibilities in a situation they choose to take up, and which they ‘suppress’ or ignore, using everyday ‘mundane’ conversation as a benchmark. This generates “a special character of speech-exchange systems that participants can be found to orient to … by selectively reducing or otherwise transforming the full scope of conversational practices,
concentrating on some and withholding others, participants can be seen to display an orientation to particular institutional contexts…” (Hutchby & Woofitt, 2008:139).

3.3 Data

Data for this study comes from an Australian metropolitan teaching hospital. It consists of ethnographic and interactional data which is described in the sections below. Access to it was facilitated by a personal contact of the researcher.

3.3.1 Ethnographic data

While the chief data source for this study was videotaped interactional data (§3.3.2), some additional ethnographic data was also collected. This ethnographic data included information about the structure of the ward round visit, participant characteristics, the physical setting for the interactional data, different bedside consultation types in this hospital, and information about sound and activity perceptible in the interaction space but emanating from outside it.

By ‘ethnographic’ I refer to observational information in addition to the primary (videotaped) interactional data. This ethnographic data is intended to contribute to our understanding of the environment and social context in which the consultations occur. This information is not extensively referred to in the data analysis, although it is used to attribute membership categorization to participants (senior doctor, junior doctor, patient, patient’s daughter etc.).

Although attending to factors beyond the interaction itself is incompatible with the ‘emic’ (data-focused) approach of ‘pure’ CA, Candlin (2011), Heritage and Stivers (2014), Stivers (2015) and others point out that interdisciplinary research involving CA as the primary research methodology increasingly also incorporates other methodological elements such as selected quantitative methods (discussed in §3.2.1, §3.8.4). Indeed, ethnographic data has been proposed to be valuable and, in some instances, essential background for CA researchers in understanding how actions and achievements are taken to be meaningful in different contexts, particularly in different institutional contexts. The use of supplementary ethnographic data in broad CA
investigations is consequently consistent with practice in the growing area of ‘Applied CA’ (Antaki, 2011).

The ethnographic data in this study was collected in several ways. First, incidentally (by observation during, and immediately before and after each consultation), Second, through informal conversations with patients during the information and consent request process that occurred the evening before each filming session. Third, during the period when the patient (and sometimes family member) and the researcher – awaited arrival of the medical team, and fourth, through conversation between researcher and patient (and/or family member) after the team had left after the conclusion of the consultation. Fifth and finally, from informal conversations between the researcher and the medical participants after the conclusion of the bedside consultation.

This additional data included limited demographic information including participant gender, observational evidence of participants’ approximate ages (exact information about participant age was not collected), also information about the types of ward rounds, level of doctor seniority, ward type, participant attire, and also interview data (this was excluded from this study because it was decided that its detailed analysis was beyond the scope of the thesis. It will be reported separately).

In addition to the regular ward round, changeover consultations occur on a weekly basis so that responsibility for patient care can be transferred between medical teams prior to the commencement of duty for the new team. These consultations involve familiarizing the incoming team with the current patient “load.” They also involve introducing patients to the physicians scheduled to assume their care the following week. Changeover ward rounds involve a larger group of medical staff than regular ward rounds that occur on other days during the week or duty period. This is because the doctors (and other medical staff – junior doctors and medical students) responsible for patient care in both the present and forthcoming weeks are present. In both regular and changeover ward rounds, bedside consultations generally occur sometime between 8.30 am and midday approximately. In this study, consultations, both regular and
changeover, took place in a range of room types from single rooms to four-bed wards (see §3.6.2 and Appendix 4).

3.3.2 Interactional data

The interactional data in this study involved team-based medical care that occurred as part of the daily ward round. It comprises 48 bedside consultations in medical wards in an Australian metropolitan teaching hospital. The consultations, averaging five minutes in duration, were videotape-recorded over an approximately nine-month period between 2010 and 2011, and include regular and changeover\textsuperscript{6} consultations (see §3.3.1 above).

This data was initially a convenience sample in the sense that I was reliant on the judgment of the medical staff in recommending patients to approach for participation in this study. Similarly, the medical staff involved were people who happened to be employed by the hospital at the time. I aimed to collect enough data to comprise a sufficient amount that a sufficient number of interactions would be captured to be able to construct a moderately substantial collection, while at the same time not producing an overwhelming amount of data for a single analyst to manage. No specific target number was discussed, and the final number collected was 48. This number was at the discretion of the head of the medical unit involved in the study. Participant selection is discussed in §3.4, and participants had to meet a set of qualifying criteria to be eligible to participate, as outlined in that section.

No explicit strategy for patient selection to be approached for participation in the study was discussed with the researcher, and decisions about this were at the discretion of the medical staff. The sample was selected on the basis of patient eligibility as mentioned above, as well (obviously) as participant willingness to participate in the study and provision of informed consent (see §3.4.2). Patient participants were selected by medical staff without consultation with the researcher on the basis of suitability and consent as mentioned above, as well as on the basis of convenience to the medical team of filming on a given day, of the patients being well enough (in the

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\textsuperscript{6} These are also known as handover consultations, but at this hospital the term ‘changeover’ was used. These occurred each Friday and were where medical teams transferred responsibility for patient care for the following week.
judgment of the medical team) to withstand the experience of being filmed. Finally, patient participants were selected by the medical team on the basis that their condition not being so acute that filming was judged by the medical team to represent an unreasonable intrusion into the patient’s privacy or the doctors’ focus in dealing with medical emergencies or crises. These criteria were not explicitly discussed with the researcher by the medial team.

The bedside consultation is the core of a ward round visit (see also §2.2.4 and Figure 8), both in terms of its sequential location within the visit and in terms of its content. The entire ward round visit comprises a bedside consultation between patient and doctor/s, and preparatory and summarizing meetings between the medical staff. These are held in the corridor outside the patient’s room, out of earshot of the patient.

The doctors-only meetings that bookend the bedside consultation vary in duration and are not included in this study. They are intended to summarize the key issues relating to the patient who is about to be visited, before the bedside consultation, and to confirm decisions made during the consultation and other outcomes of the meeting, including allocating tasks to members of the medical team, at the conclusion of the visit.

This study therefore focuses on the middle stage of the ward round visit – the bedside consultation. This has several advantages. It has made data analysis simpler in a project of limited scope, and it has generated results more easily compared to findings from other studies of medical consultations in similar and different clinical settings.

3.4 Participants

3.4.1 Participants and setting

Participants in this study were 48 patients and 11 doctors with varying degrees of experience and seniority, working in a medical team that occasionally included other allied medical personnel such as nurses and dieticians.

The distribution of seniority among the doctors was: five senior consultants (including the department head), five registrars and a number of medical students. The senior
doctors were all consultant physicians with a minimum of five years’ experience as specialist clinical consultants. The junior doctors were all registrars with between four and eight years’ postgraduate experience. The student participants were all third-year medical students.

The hospital was a training hospital, so medical students were regularly rotated between training placements at this and other hospitals, interspersed with time in regular academic study at their university. Medical students had three-month rotations at this hospital during their training program, whereas junior doctors (registrars) typically had six-month placements.

A total of five junior doctors were involved as participants in this study over the twelve-month period of data collection. Five senior supervising doctors or consultants also participated in the study, as well as a range of medical students, whose roles were almost invariably limited to observing the consultation.

There was a range of combinations of participants during consultations in the data. During any single consultation a minimum of one senior doctor and one junior doctor were generally present. During some consultations (e.g. changeover consultations), up to four senior doctors, two junior doctors and up to four medical students were present. Occasionally two or even a single junior doctor led the consultation, but usually junior doctors were accompanied by at least one senior doctor. In addition, on some occasions, only a single senior doctor was present. The fact of this level of variation of composition of the medical team resulted in the generation of data representing a range of sub-types of bedside consultation.

The senior doctors in the medical team were independent specialists working together in a loose association based on shared involvement in clinical research projects occurring in conjunction with provision of inpatient clinical care. Senior team members’ areas of specialist training and expertise included: general medicine, infectious diseases, gerontology and emergency care. They worked together in a loose academically-based association, cooperating in research projects while sharing responsibility for the care of patients in medical wards.
One or two senior doctors attended most regular rounds, as well as changeover rounds, where a senior consultant ‘handed over’ to the senior consultant rostered on for the following week, making introductions and summarizing key clinical and other issues relating to each patient to the incoming team. Junior doctors were registrars, with three years post-qualification experience working in a hospital and were registered physician trainees, and residents, who were in their first post-qualification year working in a hospital. Registrars led some regular consultations under supervision of a senior consultant, sometimes accompanied only by another registrar (C15), and usually accompanied by one or more medical students. Medical students were in the process of completing a three-month training ‘rotation’ at the hospital as part of their third-year medical studies. This rotation was one of three arranged at different hospitals for this part of their medical training and comprises part of the clinical component of the medical degree, echoing the format of traditional apprentice-style training dating back at least to ancient Greece and Rome.

Medical and other staff participants (such as nurses and dieticians) were selected by virtue of membership of the medical unit team. Potential patient participants were identified and selected by hospital medical staff and referred to the researcher for explanation of the scope and requirements of participation. Patient participants were selected on the basis of their willingness to take part in the study, on their proficiency in English, and on their mental capacity to participate (as determined by the hospital staff). Occasionally family members were present during the consultation. They were either spouses or children of the patients. In all cases, accompanying family members were women.

A greater proportion of patients were female than male, whereas there are more male doctors than female doctors in this study. The gender distribution of patient participants is as follows: 21 male participants and 27 female participants (44% male: 56% female), while the gender distribution among the doctors is: seven male and four female doctors (64% male: 36% female).
The researcher was not informed about the nature of patients’ medical conditions because this information was not relevant to the aims of the research.

3.4.2 Participant consent

Contemporary ethical standards mandate participant consent in communication research such as this. In this study participant consent was secured as follows. The day before a particular ward round, the researcher received a list of names and ward numbers of potential patient participants, in an email or text message from the doctor in charge of the medical team or from another member of the team tasked with this responsibility. This list was compiled by medical team members and was the result of preliminary inquiries they made to patients who seemed to be possible potential participants.

After the list of possible participants had been received, the researcher visited each of the people on the list the evening before the target ward round visit. On each occasion, the researcher introduced herself, and explained the reason for her visit, asking the patient’s permission to continue. When that had been given, the researcher entered the patient’s room or bedside, and explained the nature, scope and purpose of her project. She gave the patient a written plain language statement articulating the explanation she had given verbally. If the patient said that he or she was willing to participate in the study, the researcher gave him or her a consent form, which she read out, and the patient signed. A duplicate copy of the consent form was left with the patient. Sample copies of both forms are included in the appendices to this thesis (Appendix 3).

Consent of members of the medical team was arranged by the leader of the team, without direct involvement of the researcher. There was an ‘opt out’ option available for all participants who were members of the medical team. All participants had the opportunity to withdraw consent after collection of the data and were given the name and contact details of a representative of the ethics department of the hospital to contact if there were concerns about any aspect of the project.
3.5 Ethical parameters regarding data collection and use

This research was conducted within the constraints of ethical parameters laid out by the university and the hospital where the data was collected. The issue of participant consent is discussed in §3.4.2 above, and this section briefly expands on this issue, and otherwise summarizes the impact of compliance with ethics requirements on the design and conduct of the research and its reporting.

The use and dissemination of visual and sound data collected for this study was limited by ethical constraints specified by HRECs (Human Research Ethics Committees) of the university and hospital respectively. Ethics approval for conducting the study at the hospital was sought from [HREC name]. Permission was granted on 13 November 2009 (Reference number: 11-26-10-09). Ethics approval was granted by The University of Melbourne HREC in December 2009 (Reference number: 0932366.1).

There were separate but coordinated processes for obtaining hospital and university ethics approval to conduct this research. Both institutions required written descriptions of the proposed research project, and the hospital required the researcher to attend an HREC meeting to answer questions from committee members about the proposed research project.

In the case of the university, this written description was contained on a completed form designed for this purpose. The form was submitted to the university HREC committee for consideration at its regular meeting, and permission was subsequently granted subject to approval by the hospital HREC committee, as outlined above.

A similar process was undertaken seeking ethics approval for the research at the hospital. Completed forms describing the process and aims of the project were submitted to the HREC committee for consideration. A subsequent meeting of the committee requested attendance by key members of the research team to answer questions about the proposed research project. Research team members who attended the HREC meeting were the researcher and the head of the medical team, who was also the Clinical Dean at the hospital. Ethics approval was subsequently granted, the
university HREC committee informed and joint permissions were granted for the research to go ahead.

After ethics approval was granted by the hospital HREC, emails were sent out informing all medical and nursing staff about the research project. Meetings were held with nursing staff in the wards where data was to be collected, reiterating the information about the project contained in the abovementioned emails. Members of the medical team were also informed about the project after permission was received to proceed, and again on the days on which each data collection session occurred. These meetings and emails were organized and coordinated by the head of the medical team.

Sixty patient participants were approached and invited to participate in the study. Fifty-one patients accepted and gave consent to participate. Of those, two were unable to participate on the day of filming because they were too unwell, and one because s/he had already been discharged from hospital. No patient participants withdrew their consent after filming and nine refused the invitation to participate in the study.

The exact number of clinical participants informed about the project after ethics approval was granted (see above) and before the start of each of the ward rounds where filming was occurring is unknown. All participants were invited to participate in the study at this time, and they were given the opportunity not to participate by not attending or leaving consultations that were to be filmed. Clinical participants, like the patient participants, were given the opportunity to withdraw participation consent after filming had taken place. All agreed to participate, and none withdrew consent after filming.

The identity of all participants and of the hospital where the data was collected were protected in analytic and other discussion about the project involving audiences outside the research team, and also in visual illustrations of such discussions. The identity of participants and of the hospital were protected by the use of pseudonyms when referring to individual participants in public discussions or presentations, and by
the use of digital masking of identifying features in visual images incorporated into written analysis, publications or presentations (as described in §3. 5).

No data could be collected without the prior informed consent of participants. Consent could be withdrawn after having been given, even after data had been collected, however once the data had been incorporated into analysis, earlier consent was taken as continuing to hold. No consent was revoked after data collection and only two participants withdrew consent. On both occasions when this occurred, patient participants withdrew consent because they were not feeling well enough to participate. One further previously ‘consented’ participant implicitly withdrew consent and did not participate because s/he was discharged from hospital before data collection had taken place.

3.6 Data collection

Data collection methods were chosen on the basis of what would produce a range of information about interaction that could be analyzed using CA, the main analytic methodology chosen for the project. Raw data consisted of videotaped recordings of bedside consultations, collected using video cameras. The availability of video data provided the opportunity to decipher not only the basic spoken features of the interaction, but also to capture its nonverbal aspects.

The Observer’s Paradox (Labov, 1972), where participants in observational research are aware that they are being observed and this knowledge affects their behavior, is relevant in this research. During the process of data collection in this research, participants knew that they were being filmed and at times this observably affected their behavior. For example, participants sometimes made jokes about being filmed or glanced at the camera then looked away during filming. This is discussed with reference to the data in this study in Chapters 6 and 7. However, in general, study participants seemed to ignore the cameras or forget that they were being filmed, and their interaction appeared to be ‘natural’ and unaffected by self-consciousness or the intention to behave in any particular way.
Equipment used was a hand-held Canon video camera, a Sony HDR CX55OVE Handycam, and three small video cameras, placed according to the design of the room to capture the maximum amount of relevant visual information. An Apple iPod Classic, with a mounted Belkin TuneTalk Stereo microphone, was placed near the patient to supplement the sound recorded by the video cameras, which was particularly useful when participant voices were soft or there was competing sound from outside the interaction space. The objective was to record sound from and collect images of the participants’ faces and bodies, as well as a view of both or all participants in a given interaction, together. Details of filming and camera placement are discussed in §3.6.3 below. Participants did not have pre-allocated positions in the interaction space, making it impossible to know exactly where members of the medical team would stand. This meant that despite the number of fixed cameras, there was no guarantee that any of them would collect useable vision except for the researcher’s hand-held camera, and the tripod-mounted camera facing the patient, located at the end of the bed. Camera placement is illustrated in Figures 2 and 3 below.

Recording equipment was positioned in the consultation space immediately before the consultation began. Because consultations were recorded in groups, several encounters were recorded on a particular day in ‘real time’, the researcher consequently accompanied the medical team on their ward rounds, moving ahead of them to have time to place the equipment in the space of consenting patients before the team arrived.

3.6.1 Data transferral and management

Video data is now standard for CA research and is an excellent resource for capturing, closely examining and keeping information that can be returned to and carefully examined subsequently in different ways in attempts to capture the complex structure of face-to-face interaction, subject always to the agreement and informed consent of participants (Heath, Luff and Svensson, 2007). The interactional data was video recorded, processed and managed as set out in this section.

After each filming session, the video data produced during the session was downloaded onto my computer and labelled with the consultation number, as well as
with information stating which video view each item of footage represented. That is, labelling identified whether each segment of video was filmed by the tripod-mounted camera facing the patient, from the shelf behind the bed facing the medical team or by the hand-held camera operated by the researcher. This practice allowed me to group segments of footage related to each of the consultations together for synchronization (in Elan) and as the source of the transcriptions.

Video recording from each of the cameras was uploaded onto the researcher’s computer using USB ports (Flip Mino cameras) and connector cables (Sony Handycam), and inspected for useability after each episode of data collection. ‘Useability’ refers to how much of the interaction between doctor, patient and the medical team was visible in the footage. As noted in §3.6.3 and illustrated in Figures 2 and 3) below, cameras mounted on shelving behind the head of the patient’s bed often failed to capture useable views of the consultation interaction.

All video footage was entered into Elan (video transcribing software). Footage from the camera that was turned on first (usually the tripod mounted camera shown in Figure 3 below) was used to synchronize footage from the different cameras. This was because the camera activated first contained more footage than the others, and also because the tripod-mounted camera generally captured the clearest sound. Synchronization of footage from different cameras was done using Elan.

Because guesswork was required in the placement of video cameras on the shelving behind patients’ beds (See Figure 3 below), the angles at which they had been placed quite often failed to capture the action of the consultation and as a result their data was not useful for the analysis. Camera sight lines are illustrated in Figure 4 below. Two cameras produced consistently useful video data: the hand-held camera operated by the researcher, and the camera located on the tripod at the end of the patient’s bed, facing towards the patient (Both are shown in Figure 3).

### 3.6.2 The interaction space

Interaction space is important because it physically constrains and thereby influences and helps shape the interaction that occurs within it. Not only is the amount of space
available for participants to occupy influential, but the level of light, colour, degree of clutter, noise level, and amount of visual movement and distraction present all bear upon the form and composition of interaction that participants co-construct within the space.

The consultation space is discussed here with reference to the four-bed ward (see Figure 1 below for a typical layout). Consultations also occur in single bed wards or private rooms, and in shared two-bed wards. All three ward types are described and shown diagrammatically in either this section (four-bed wards) or in Appendix 4 (single rooms and two-bed wards).

Almost half (48% or 23/48) of the consultations in this study occurred in four-bed wards making this the most well represented ward type in this data.

The ward is in essence a large room lit by large windows at one end that let in enough light that even in overcast weather and (combined with electric lighting in the rooms) made the wards light, bright spaces. Possibly for this reason, during the day most patients keep (or are encouraged to keep) their curtains open, with the result that the entire space remains quite light and welcoming. Four-bed wards are organized with a curtain rail suspended from the ceiling running around the perimeter of the space allocated to each bed. This allows curtains to be drawn around beds when patient privacy is required. Despite not providing any meaningful level of aural privacy, the curtains nonetheless provide a visual indication to those outside it that privacy is desired by and for the patient within.

Each bed space contains an armchair, a chest of lockable draws on castors as well as a moveable tray table for patients to eat meals from, or use as a surface on which to write, read or keep water within reach when needed. A TV is also suspended from the foot of each bed and can be operated by the patient via a hand-held remote-control device connected close to the head of the patient’s bed. The patient also has access to a control device that can alter the angle and height of the head of the bed. Further details of ward layout are provided in Appendix 4.
When data was collected from beds located in shared wards, particularly in four-bed wards, occasionally noise emanating from outside the interaction space intruded into the data, affecting the audibility of speech to both participants and researcher. Heavy cotton curtains drawn around each bed and its immediate surroundings along a curtain rail help to provide visual privacy but not complete aural isolation from adjacent areas, thereby providing only a measure of overall privacy to the patient (as well as to doctors) during the consultation.

When the medical team enters the ward before beginning the bedside consultation, its members walk past this area into the ward to the space occupied by the patient they have come to see. In smaller (namely one- or two-bed) wards the effect of this entry is of walking through a corridor, something that was different in the larger (four-bed) wards, where the entry is wider and more open, and often has a more informal feel or appearance to observers (as well, possibly to participants).
As the number of occupants of the ward rises, so (often) does the associated ambient noise from talking or television, as well as from the sound of people coming and going into and out of the ward. These effects are amplified or modified by the floor treatment, with hard (e.g. linoleum) floor coverings being more reverberant,
particularly in combination with the large expanses of wall and relatively little soft absorbent material) of the ward, and carpeted wards being relatively less reverberant and so quieter.

In addition to this, the larger the ward, quite often the more the associated potentially distracting or unrestful visual activity and stimulation. Again, this often comes from the traffic of people coming and going into and out of the ward, from doctors, to visitors, to people bringing around tea trolleys or newspaper trolleys for patients, nurses administering medications, taking readings or collecting other information, and cleaners tidying the room overall, changing beds, emptying wastepaper baskets or other routine or special cleaning tasks. Prior research has shown potentially more and less beneficial aspects of being accommodated in wards shared with other people for patients, from the perspective of consultation duration, number of questions asked by patients and the level of detail of doctors’ responses (van der Glind, van Dulman & Goossesen, 2008). In this study there is evidence of the effect of ambient noise on interaction during consultations, less unequivocal evidence of the effect of visual distraction or stimulation.

3.6.3 Camera placement

Different room configurations provided participants with slightly different interaction spaces however the challenges of camera placement were similar in each room type. The aim of filming was always to capture the greatest possible variety of views of participants during the interaction. Patients in this study were accommodated in a range of possible room types, from single rooms to six-bed wards. The layout of the single or private room is described in this section, to show the basic issues affecting data collection.

Up to four cameras were used each data session, positioned to capture the maximum number of useable views of the interaction. Up to three of these views were static, where small cameras were positioned on shelving and a tripod to capture views of the patient, and participating doctors and other people present (see Figures 2 and 3 below). One view was filmed by the researcher, using either the Canon or Sony Handycam,
making it possible to film participants (usually the doctor) if they moved around in the space.

Figure 2  Placement of static cameras on shelves above the bed, facing the medical team

Cameras were placed on the shelves behind the patient’s bed before the arrival of the medical team. These were positioned facing the same way as the patient (pointing away from the wall behind the bed) positioned at a height intended to capture views of several of the consultation participants (See Figure 2 above). Because the exact eventual location of members of the medical team in the consultation space was impossible to predict in advance, footage recorded on the shelf mounted cameras was not always useable. In every consultation, a small tripod-mounted camera was placed at the end of the patient’s bed, directly facing the patient (see Figure 3 below). This camera reliably captured the patient’s face throughout the consultation.
Figure 3  Placement of static cameras on shelf, and on tripod facing the patient

The range of sight lines captured by camera placement is shown in Figure 4. The fixed views are intended to capture the patient’s face and as many members of the medical team as possible, whereas the researcher operated moveable views are designed to follow the patient and doctor together as, when and if they move.

Figure 4  Camera sight lines

Key: Blue lines represent fixed sight lines (from cameras in fixed positions); Orange lines represent mobile or responsive sight lines (from researcher-held camera that can be moved).
Software

Video editing, streaming and other software was used to prepare video data for analysis and presentation in this study. Data collection occurred before development of the current generation of smartphones (e.g. Apple iPhones), an advance that facilitated integrated video recording and storage. For this reason, Quicktime 7 Pro software was used to convert video files into audio files. VLC video editing software was used to convert video footage taken on the handheld Sony Handycam camera and on MinoFlip cameras into a form that could be manipulated by video animation and editing software such as Elan.

Adobe photoshop was used to pixelate still images created using VLC software to illustrate features of interaction discussed in the analysis, so that identifying features of participants and the hospital environment could be masked.

Hospital ethics requirements stipulated that all study participants must have their identities protected, as did the hospital where the data was collected. To satisfy this requirement, faces and other identifying features of people, documents and spaces were digitally masked in screenshots and other still images used to illustrate written or oral discussion about the data.

A decision was made not to use video clips in the thesis and in presentations because still images were sufficient for presenting the analysis. This study was not intended to produce a highly detailed multi-modal analysis, so still images were considered to be suitable for highlighting embodied action that was the focus of discussion at different points. A detailed study of the interplay of speech and embodied action during bedside consultations would be an interesting focus for future research. Topics could be addressed such as what happens at key points of the consultation, such as points of transition, tension or conflict could be explored in detail to see how they are worked through interactively by participants.
3.8 Data analytic approach

This section details the analysis of the data in this study.

The consultation data was analyzed using CA and some supplementary quantitative analysis. Collections of different organizational structures of the consultation were made using CA methods and techniques (described in §3.8.3). These included: phases of the consultation (opening, closing and consultation core), activities within the phases (entry, greetings, settling in and registering, introductions, pleasantries/howareyou sequences, case presentations, verbal examination, physical examination, specialist feedback sequences, procedure feedback sequences, diagnosis update, treatment discussion, discharge discussion, summarizing the condition, making/finalizing arrangements, farewells). My focus in the activities within the phases was on previously undescribed activities that may be distinctive in this (particular) clinical setting. Some other phenomena were also collected, including address terms.

Selected items from among the phenomena in the CA collections were also counted to provide a general sense of context for the CA analysis in the final presentation of results in the thesis. Details of the quantitative procedures are presented in §3.8.4 below. Much of the phenomena collected for the CA analysis was also ‘counted’ to provide general context for the qualitative findings. Phenomena counted included: speaking turns, (location of) case presentations, greetings, settling in and registering, introductions, pleasantries/howareyou sequences, case presentations, verbal examination, physical examination, specialist feedback sequences, procedure feedback sequences, diagnosis update, treatment discussion, discharge discussion, summarizing the condition, making/finalizing arrangements, farewells. Supplementary ethnographic data that was also counted included consultation (and phase) duration.

The primary aim of this study is to create a structurally-based broad brush ‘portrait’ of the bedside consultation, based on analysis of the data described above (§3.3). The research questions that frame the study focus on two structural aspects of the consultation: its overall structural organization (RQ1, Chapter 4), and its organization at each of three major structural components (or ‘phases’) of the overall structural
organization. Three further RQs explore the organization of each of these three phases: the opening (RQ2, Chapter 5), the consultation core (RQ3, Chapter 6) and the closing (RQ4, Chapter 7). The analytic approach outlined above is intended to support and help achieve the aim of the study.

The procedures, content and motivation for this analysis is described in this section. This section describes the data analysis in this study. It outlines the procedures by which the data was analyzed, exactly what aspects of the data were analyzed and how these analyses related to the RQs and contributed to achieving the aims of the study.

An initial outline of the analytic approach of the study is presented in §3.8.1 and the transcription of talk and embodied interaction is discussed in §3.8.2. The CA analysis, including its process and an account of the phenomena analyzed using CA are outlined in §3.8.3, while the quantitative analysis – ‘things’ that were counted and the procedures used to analyze them – are discussed in §3.8.4.

Finally, in §3.8.5, an account of the integration of the qualitative and quantitative analyses in this study is presented.

### 3.8.1 Outline of analytic approach

Analysis of the videotaped interactional data was chiefly done using CA, including using CA-style transcription, based on protocols originally outlined by Gail Jefferson and refined over time by others including Hepburn & Bolden (2014). The CA transcription of the consultation is discussed below (§3.8.2) and procedures used in analysis of the interactional data, are discussed in §3.8.3. Key concepts in CA are outlined in §3.2.2 above.

CA investigations focus on a range of interactional phenomena ranging from particular kinds of action to ways of responding to particular kinds of actions, always with the aim of discovering, on a case-by-case basis, what interactional work these phenomena achieve (Hutchby & Wooffitt, 2008). CA-style ‘collections’ of phenomena were made that were extended sequences of talk, and thereby larger scale than the phenomena
motivating many CA studies, but which were the means of accomplishing action at the bedside, which was the reason for my selecting them.

In addition to the qualitative CA analysis, selected frequency counts were undertaken of aspects of the interactional data (see also §3.2, §3.8.4). These counts focused on phenomena emerging from the CA analysis described in this section (below), including activities occurring during the opening, closing and consultation core, the format of ‘opening elicitors’, and configuration of terminal sequences. I also counted ethnographic features of the consultation including the duration of different consultation phases. These counts linked with and (I argue, enhanced) discussions in RQs 1, 2, 3 and 4. Since these counts involve a data set too small for statistical tests to be validly applied, it is not possible for me to make claims generalizable beyond this data set on the basis of my results. Consequently, I make no claim that patterns emerging in this study apply beyond this single data set. A full discussion of the quantitative dimension of my analysis is discussed in §3.9.

I chose to include frequency counts in my analysis to help test and clarify my sense of the routine-ness of practices and activities that participants undertook, emerging from the CA analysis of the consultations as mentioned above. This basic quantitative analysis allowed me to do this in a way that is not completely different from that expressed in the CA idea of ‘collections’ of practices. A similar point is made by Stivers (2015) in her paper discussing the compatibility of quantitative analysis with CA and the legitimacy of using statistical analysis in combination with CA. Stivers (2015) suggests that counting interactional phenomena that arises out of CA analysis of naturally occurring data is a legitimate supplement to the CA analysis.

The purpose of the simple quantitative analysis was therefore to allow me to identify patterns in the structural organization of the consultations in my data, and to strengthen claims I made about their prevalence in this current data set.

My aim in analyzing the video data and transcripts was to get a sense of how participants organized the work of the bedside consultation, and the CA approach to investigating naturally occurring (inter-) action seemed well suited to helping me do
this. After transcribing the video data, I became aware of the fact that the work of the consultation was organized, as has been previously been reported in other settings (see Chapter 2) in a series of broad phases and within those, subsidiary task-based activities. This pattern was noticeable in consultation after consultation, and I decided to use it as the basis for my overall study. I reviewed each transcript with this in mind, first identifying the broad phases (which I called ‘opening’, ’closing’ and ‘consultation core’) and then looking more closely to try to identify the activities participants were undertaking within those broad phases.

The activities I began to notice participants undertaking seemed to be tied to the tasks of the consultation, and I then worked to identify and name them. I noticed that some of these activities were similar to those described as occurring in other clinical settings, but some were different. I also noticed that sometimes activities that had already apparently been completed were restarted. I decided at this point to treat the entire transcripts of the entire data set as a collection that I could use to explore in a more focused way whether the sense I had had of certain phases and activities occurring in consultation after consultation was actually borne out. Similarly, whether the iterative pattern of sequences of activities within the consultation phases (particularly in the consultation core) was repeated across the data set. The consultation phases and the activities that occurred within them, as well as the sequencing of those activities therefore became a focus of my analytic interest.

At the same time, I became curious about how the activities themselves were organized. I used the CA analytic strategy (ten Have, 2007) of investigating four key dimensions of interaction – turn-taking organization, turn design, sequence organization and turn design - as a way of better understanding this and as a further ‘way in’ to the data. Despite the fact that, as mentioned above, my data set is small, making it impossible for me to make claims about my observations that extend more widely, there is still a substantial amount of interactional data in my 48 consultations for a single analyst to explore. For this reason, I decided to limit the focus of my study to the two key elements of organization I have described in this section: the overall structural organization of the consultation, and the organization of the activities with in
its phases. In particular, I have chosen to focus on the activities that do not routinely occur during consultations in other settings according to the current literature.

### 3.8.2 Transcription

In this section I outline some key issues regarding transcription of videotaped data (§3.8.2.1), and in the following sections (§3.8.2.2, §3.8.2.3) I describe how speech and embodied were transcribed in this study.

#### 3.8.2.1 Representing talk and embodied modalities in Conversation Analysis

Transcription is the first phase of analysis (Ochs, 1979, 2006), and transcripts are the result of interpretative analytic decisions and choices made by the transcriber about what they are hearing and/or seeing in a recorded interaction, based on the rules of some kind of transcription method or protocol. This means that a transcript is analytically constructed by the transcriber based on video (or audio-) taped naturally occurring (or not naturally occurring but experimental) interaction and is not a neutral verbatim ‘report’ or direct translation of an interaction.

The interpretative nature of transcription referred to above means that the transcriber is free to focus on particular features or characteristics of interest and ignore features of less interest, or represent those features in less detail, thereby exercising editorial prerogative in producing the transcript in order to best achieve his or her research interest or focus (Sidnell, 2010). Alternatively, in observing interaction, different features or communicative modalities may seem to be more important to participants at particular moments and the analyst may choose to shift the focus of the transcript in order to accommodate these apparent interactional shifts (Mondada, 2015).

An additional point is that transcripts are always provisional, and in the course of analysis of different aspects of the data they represent, adjustments and refinements can be and generally are often made (Clift, 2016).

CA treats *naturally occurring interaction* as an event when participants do things and where no detail can be treated as irrelevant or worthless and consequently to be edited
out. Notwithstanding this belief in the significance of all aspects of interaction, analyses must be selective to some extent, as mentioned above, because it is seldom or ever possible to equally address all aspects of the complex phenomenon that is a conversation or other face-to-face exchange. Research questions correspondingly focus on only some facets of what occurs in the data, so it is appropriate as well as practical to be selective in what is shown in detail, and what is shown in more ‘broad brush’ terms (Hepburn & Bolden, 2014).

Descriptions of how transcription is used to show features of talk and embodied action in this study are given in the sections below. These Jeffersonian-style protocols are well known and widely used in interaction research, and show features of interaction that Sidnell (2010:ix-x) groups into the following broad categories: “Temporal and spatial relationships…Aspects of speech delivery, including aspects of intonation, … and other markings”.

The aim of CA style transcription is to capture in detail what is said (and done) during an interaction, and to capture and represent how it is said (and done). To do this, such features as speech, overlapping speech, pauses in conversation, lengthened words or words cut short, areas of emphasis or change in intonation are all marked. Audible features such as inbreaths, laughter, and particular tones of voice (e.g. ‘laughing tone’) can also be shown, as can embodied actions (such as gaze, hand – and other – gesture, body posture and movement, and head movement).

Jeffersonian CA transcription protocols provide the flexibility to ‘zoom in’ and ‘zoom out’ on different levels and types of detail in transcripts to fit the research focus. This idea of flexibility seems to have been implicit in Harvey Sacks’ (sole) instruction to Gail Jefferson to “just write down what you hear” (Sidnell, 2010:24). It is also referred to by Mondada (2007).

Many transcripts represent verbal and embodied communicative action so that a broad sense of how the consultation is conducted can be shown. However, as mentioned above, only features relevant to the associated analyses are included. For this reason, actions such as gaze shifts, facial expression, hand or arm gestures, head or body
movement and the way space is occupied (proxemics), or particular aspects of speech delivery are represented at points in transcripts where they seem to play particularly important roles in what is being done at the time, or contributions to action that are relevant to the focus of a particular discussion.

CA and its transcription system were developed before video recordings made visual as well as audio dimensions of interaction available for repeated observation. For this reason, the system originally included only symbols for representing spoken and aural phenomena. Since CA and its transcription system were first developed, research into embodied aspects of interaction and their role in interaction systems overall has been conducted by a number of researchers and from a range of perspectives. This work has generated protocols for representing gesture (Kendon, 2004) and eye gaze (Rossano, 2012; 2014), (Goodwin, 1986) (Goodwin & Goodwin, 1996) and multiple embodied modalities (Mondada, 2018; 2007).

However, no widely adopted and comprehensive system for representing different aspects of embodied action alongside talk in interaction has yet been devised. The role of embodied elements in interaction has also long been acknowledged in the CA literature (Heath, 1986, 2006; Robinson, 1998; Sidnell, 2010; Clift, 2016), and work in the area of discovering and showing how this happens has been underway for some years. However, the centrality of embodied action in face-to-face interaction is increasingly acknowledged in the CA literature, particularly in recent work of Lorenza Mondada (Mondada, 2018) in developing ways to incorporate embodied elements in CA transcription systems and introducing the term ‘Multimodal CA’.

Schematic drawings or diagrams can also be used to represent embodied action during interaction (Bolden & Hepburn, 2018), but apart from those illustrating the different ward configurations in this study in §3.6.2, such representations are not used in this study.
3.8.2.2 Transcribing talk and non-speech vocalisations

The way speech, non-speech vocalisations and embodied action were transcribed in this study is outlined in this section. A model of different components of interaction included in transcripts in this study are shown in Figure 5 below.

All transcriptions in this study were made by the researcher, without assistance from others. The main reason for this relates to the point made earlier about the importance of the transcription process as a means of examining and getting to know the data. Transcription was therefore a vital first (and subsequent) means of exploring this data.

Speech, non-speech vocalisations and silences are transcribed using protocols originally outlined by Gail Jefferson (1983, 1985, 2004). Jefferson’s transcription has been developed since to accommodate reference to different features of embodied action (see discussions by Hepburn & Bolden, 2014; Sidnell, 2010), and this system and its variants are widely used in CA research and are outlined in Appendix 5.

In the remainder of this section I summarize of different elements of interaction that can be and are represented in transcripts in this study and/or are referred to in the text of analyses in the results Chapters 4 - 7. I have divided these elements into embodied and verbal elements, and I precede the examples with a chart showing a range of these different communicative elements in terms of their relationship to actions and to each other.

I have divided these communicative elements into three levels which I have called ‘Domains’. The top level of the hierarchy represents the action (which as mentioned in §3.2.2 is one of the ‘Two [key] Things’ (along with sequence) in interaction Clift (2016)). I have called the top level the ‘Communicative Domain’. Because that domain (only) comprises ‘Action’, the next level down in the hierarchy is called ‘Action Domain’. At this level I represent different modalities of action. The lowest level on the hierarchy I have called ‘Domain categories.’ At this level, I show different varieties of each action domain shown in the middle level.
**Figure 5  Components of interaction**

- **Communicative domain**
- **Action domain**
- **Embodied resources**
  - Speech
    - Words
    - Silence, pauses
    - Overlap
    - Laughter
    - Particle
    - Continuer (e.g., 'hmmm')
    - Emphasis & intonation
    - Volume
    - Duration
  - Non-word vocalizations
    - Gaze
    - Gesture
    - Head movement
    - Proxemics
    - Body movement, posture
    - Facial expression
3.8.2.3 Representing embodied modalities

Embodied action is represented in this study by transcriber comment or descriptions enclosed in double brackets at points in the transcript where the target phenomena occur. This simpler way of indicating embodied action is justified here because detailed, fine-grained multimodal analysis is not the focus of this study. Although embodied action is undeniably intrinsic to the accomplishment of action during the consultation, in this study its role is more indicative than central, and it is treated analytically as an adjunct to help and enrich the more general, speech-focused analysis. Further research focused specifically on the role of embodied action in the bedside consultation would make an interesting extension to this study.

Transcriber comments enclosed in double brackets describing embodied action are placed as close as possible to corresponding or just prior speech in the transcript. In a variation of the standard Jeffersonian protocol, I show all silences on their own lines in the transcript to give a clearer indication of the ‘shape’ of the interaction. Moments of silence often accommodate shifts of interactional focus from speech to embodied action. By giving these moments dedicated lines in the transcript, there is more space to describe embodied action/s underway without interfering with the representation of neighbouring speech and showing, in a written transcript, the pattern of co-occurrence of speech and embodied action more clearly.

Aspects of embodied action referred to and included in transcripts in this study include: Proxemics (how participants use their bodies to occupy the interaction space), hand and arm gesture and body movement, gaze and head movement. Because usually different communicative channels usually (or often) co-occur during face-to-face interaction, descriptive references to them in the transcripts often mention a group of embodied actions where it seems relevant to do so. This can be seen in some of the examples shown in Appendix 8.

Embodied interaction is an integral part of face-to-face communication, and investigation into its role in this form of interaction has given rise to a substantial and growing literature (Heath & Luff, 2014 for a comprehensive summary). Co-present
interaction is very complex, and participants often activate multiple communicative channels in the course of their communication. This has made clear representation of multi-channel interaction difficult for researchers, who continue to investigate this aspect of interaction and how it is integrated with speech, and develop ways of showing this (Mondada, 2018).

Several different protocols have been devised by researchers working with embodied communicative action to represent particular channels of embodied action that co-occur with speech, in a transcript. Such representational systems include protocols to represent gaze (Rossano, 2012, 2014) and hand and arm gesture (Goldin-Meadow, 2005; Green, 2009; Kendon, 2004; 1994; McNeill, 1992, 2005).

Software has been (and continues to be) developed to show multiple communicative modes simultaneously for analysis (e.g. ELAN), however, to date no widely recognized and used comprehensive system of transcription integrating co-occurring verbal and embodied communicative action in interaction has been devised. Methods used to transcribe embodied action include transcriber comments, specialist transcription and notation systems and visual representations (Hepburn & Bolden, 2014:70).

Proxemics is a term referring to the way space is meaningfully occupied by people or spaced is used “especially …the distances between speakers, to produce interpersonal meanings in language use” (Jewitt, 2009:303). Proxemics is discussed during analysis and incorporated into interpretation of interaction during the consultation. Proxemics is represented in transcripts by enclosing a description of how participants are using interaction space in double brackets (Hepburn & Bolden, 2014). This is shown in Appendix 7 (Extract 10A).

Posture and body movement, in common with proxemics, are described enclosed within double brackets in transcripts and referred to in discussion about interaction during the consultation. An example of how posture shift is referred to transcripts of this data is shown in Appendix 7 (Extract 11A).
Gaze direction in written transcriptions is described enclosed in double brackets as mentioned in §3.7.2.6 above. In still images illustrating written analysis, gaze direction is indicated by directional arrows running from individuals’ eyes towards the focus of their gaze. This is important because identifying facial features such as eyes cannot be shown – and are pixelated - for the purposes of preserving participant confidentiality (as discussed in §3.4). Changes in gaze direction or the establishment of mutual gaze (referred to in transcripts as ‘MG’) are described in double brackets in the transcript where relevant (often in combination with observation about other co-occurring embodied action). An example is shown in Appendix 7 (Extract 12A).

Head movement in two key directions is coded: sagittal (side-to-side) and up-and-down (‘nodding’/’nods’). Head nodding has been shown to be (among other functions) a resource for recipients of (story) tellings to display affiliation with the stance taken by the teller to the event/s recounted, as displayed in the prior turn during tellings (Stivers, 2008). Head nodding can also act to make an offer, for example to make a bid at an auction (Heath & Luff, 2014). To illustrate how head nodding can be represented in a transcript, I refer to an example cited in Heath & Luff (2014) shown in Appendix 7 (Extract 13A). Using nodding in this way (to bid at an auction) can be taken to express alignment with a course of action that has been initiated or is underway, such as a bidding sequence.

Kendon (2004)’s categories for describing hand and arm gesture are used occasionally in this study. They include metaphoric (representing abstract concepts), iconic (depicting concrete objects), deictic (pointing), grappolo (grasping) and beat (often repetitive up-and-down counting type) gestures. These coding categories are sometimes used (when relevant) in written analysis and in the transcripts to differentially describe hand and arm gesture.

3.8.3 CA analysis

My CA analysis was designed to support my aims of (1) describing the bedside consultation and (2) presenting evidence in the form of descriptions of unique or distinctive activities to support my argument that this is a distinctive kind of consultation where participants manage unique interactional challenges, and that this
uniqueness is reflected in a distinctive organizational structure. This CA analysis broadly followed CA methods described in the literature (Clift, 2016; Hutchby & Wooffitt, 2008; Sidnell, 2010; ten Have, 2007) and I describe its process and analysis in this section.

The CA analysis had two dimensions. I describe the overall structural organization of the consultation as a whole (Chapter 4), and also distinctive activities in closer detail (Chapters 5-7). To do this I made ‘collections’ of descriptions of the overall consultations, derived from transcripts of all the consultations in the data, as well as of distinctive activities and activities found elsewhere but seemingly done distinctively at the bedside.

Observation of the consultation data, initially in the video recording and subsequently in the transcripts derived from the videos, as well as subsequent re-viewings of the video recordings, led to my decision to describe the overall structural organization of the bedside consultation, and the activities co-constructed by participants within the broader sections (or phases) of the consultation (Chapter 4) and shaped the investigation.

Some activities undertaken during the consultations in this study have not previously been described in the literature, and this suggests that they may be distinctive to this particular setting or to the bedside consultation as a type of medical consultation. Description of these activities was prioritised over those that have been described in other settings, as was discussion of activities that have been described as occurring in other settings but seem to be done differently at the bedside, based on evidence from this data. These seemingly distinctive activities and practices formed the basis of my CA analysis and of the associated discussions in Chapters 5, 6 and 7.

3.8.3.1 The process of the analysis

In this section I describe process of the CA analysis of my data before outlining the ‘collections’ I made in the following section, 3.8.3.2. In keeping the CA emphasis on how social action is achieved in different settings, the broad focus of my analysis of
the data was on what participants were *doing* in the consultation, and how, when, and then why.

After collecting the naturally occurring data using video recording, I watched the video repeatedly before and during making transcriptions of each bedside consultation. I used ‘Jeffersonian’ transcript conventions (outlined in Appendix 5), enhanced with descriptions of embodied action that co-occurred with speech during the consultations (as outlined in §3.8.2.3). Over the course of the subsequent CA analysis, I watched and re-viewed the video data repeatedly. Once I had made transcriptions for each of the 48 consultations, a process of periodic refinement began as I recognised previously unnoticed features.

As well as periodically referring back to the raw video data through the process of analysis, I also referred to relevant literature to improve my understanding of what previous researchers investigating similar interaction had reported and described about things I could see happening in my data.

After they had been compiled, the transcripts for the consultations became key sources of data, in combination with the video. Although 48 consultations comprised a small data set from the perspective of using quantitative analysis on it for most features, it represented a substantial data set for me to analyse using a microanalytic method. I wanted to find a way of making the best use of it that I could while fitting into a gap in the existing literature. For these reasons I decided to describe the bedside consultation as a whole, looking at its structure from that perspective and then from the perspective of component parts. At this point the transcripts had become my initial CA ‘collection’ as the consultation as a whole was the first phenomenon of interest I chose to examine.

My initial examination of video recording of consultations in this data, and subsequent transcriptions, along with reading of relevant literature, made me decide to describe the organization of the consultation at different levels, with a secondary question of whether this consultation was different from consultations in other settings, and if so, how. By focusing on ‘organizing the consultation’ I mean examining how participants
in the consultation organized the work they had to do into activities and groups of activities. At a lower level, I examined the organization of activities themselves to discover what actions and series of actions were used to accomplish that work, and at a lower level still, what interactional strategies (e.g. turn design, word choice, sequencing, timing, deployment of embodied action etc.) were used to construct activities.

The focus of this study was therefore guided by this aim of producing an overall picture of this kind of medical consultation, drawing on research in other clinical settings as mentioned in Chapter 2, and on observation of the data. Because little had been published about the bedside consultation as an entire event, and about how its components were organized by participants, I decided to begin by making overall structural organization as an initial ‘key’ to my data (ten Have, 2007).

After repeated viewing of the video footage of consultations in the data, and creating and refining transcripts based on that viewing, I observed that participants seemed to treat the event of the bedside consultation as having three key components, there was an opening, a closing and ‘things’ to do with ‘business’ in between. Therefore, despite the fact that much prior research into the organization of medical consultations in other clinical settings (§2.3.1.6) described consultations in terms of a series of sequentially organized activities (Robinson, 2003; White, 2011), I adopted the simpler three-part model to investigate the consultation as well as to structure my thesis (but see Heritage & Clayman, 2010). I called each component of the consultation a ‘phase’, in order to be free to unambiguously discuss the components of each phase as ‘activities,’ each of which displays participants’ solutions to different interactional problems (such as how to begin the consultation, how to bring the consultation to a close, how to accomplish a range of tasks to be done during the consultation).

The structure of my thesis allowed me to report what I observed occurring during different parts of the consultation, but also to do so in a form that itself echoed the form of the consultation. This is because in choosing to use a three-part structure to represent what I observed participants doing in the consultation data, it was also clear
as mentioned above, that participants organized their actions/tasks in each phase using
a series of activities.

In order to investigate the internal structure of the three phases, I created a second set
of ‘collections.’ These were collections of each of the three phases. As part of this
process I created transcripts for each of the phases, one per consultation per phase.
Consequently, each consultation had three transcripts which allowed me to examine
each of the consultation ‘phases’ in each of the consultations more closely. In
examining the consultation data phases, referring repeatedly to videos and transcripts, I
noticed that participants oriented to the co-construction of certain activities within
these phases. A number of these activities accomplished tasks similar to those
described in the literature concerning medical interaction in other settings. These
similar activities included greetings, opening elicitations, verbal and (sometimes)
physical examination, treatment discussion, pre-closing and other closing activities.

However, there were some activities that recurred across the data set that had not been
described in medical consultations in other settings. I provisionally took these
activities to be evidence of distinctive or unique activities being relevant at the bedside
that as far as we knew were not evident in other kinds of consultations. Relatedly,
distinctive activities suggested that participants co-constructed these to address
similarly distinctive problems that distinctively characterised the bedside consultation.

I decided to make a further set of collections, focusing on the previously
undocumented activities I noticed participants co-constructing, or some not described
in this setting, or not described micro-analytically. These activities were:
introductions, case presentations, registering, discharge discussions and two subsidiary
forms of information gathering that seemed to accomplish tasks peculiar to this setting
which I called ‘Specialist Feedback Request’ sequences and ‘Procedure Feedback
Request’ sequences. With each of these collections, I initially examined single
instances using the four levels of “interlocking ‘organizations’” (ten Have, 2007:164)
of turn-taking organization, sequence organization, repair organization and the
organization of turn design.
I did not choose further ‘lower level’ interactional features to ‘collect’ but instead decided to choose a selection of examples of the different activities represented in my ‘collections’ and that that characterised the consultations in my data to present in my thesis. I used these instances from my collections to describe the consultation during each of its three phases (which I called ‘opening’, ‘closing’ and ‘consultation core’) through the activities co-constructed by participants. In doing this, I aimed to create a ‘portrait’ of the consultation, that revolved around structures at different levels – from individual activities to phases and the consultation as a whole (which was actually part of a larger visit structure – of the ward round visit, that I did not document in my study.

3.8.3.2 Phenomena and collections in the analysis

CA analysis therefore involves the identification of phenomena of interest, which are described in individual cases, and in collections of individual cases. These phenomena can be any aspect of interaction that strikes the analyst as of interest, and these are often practices at the level of turn design, reference formulation, action format, or sequence organization (Sidnell, 2010). The phenomena collected in this study were larger scale, namely consultation phases and activities as well as the consultation as an entire event, as explained above.

The focus of interest in a CA analysis “the interactional work being accomplished via turns at talk” and “how the items in a collection achieve their interactional effect” (Hutchby & Wooffitt, 2008:105). Phenomena of interest can therefore be identified by different means, according to what they are. For example, they can be identified by their formal features, or by their sequential location in relation to surrounding turns.

In this study, my focus ranged between higher level organizational features of the consultation (such as consultation phases) and lower level features (such as address terms). The descriptions of the phenomena I collected (below) are therefore accordingly varied. Larger level phenomena are described in terms of their sequential location in the visit while some lower level phenomena are described in formal terms. Because the number of collections I made is quite large, in the section below I
generally describe the phenomena and include a reference to where an example can be 
found in the body of the thesis.

With this in mind, and with reference to each of the 48 consultations in my data set, I 
identified all the activities that occurred during bedside consultations in my data, 
where they occurred with relation to each other and to the consultation as a whole. In 
focusing in more detail on a selection of activities, I focused on the activities that 
might be unique to this setting. I sought evidence that particular activities “actually 
and routinely occur” (Robinson, 2003:456). I also collected incidences of particular 
activities that despite occurring in other clinical settings, seemed in this data to be done 
distinctively.

I made collections of the following:

The overall consultation. The overall consultation is the interaction that occurs 
between the arrival of the first member of the medical team in the consultation space, 
and the departure of the last team member at the conclusion of the consultation. A 
such transcript of an entire consultation is shown in full in Appendix 6.

Openings. The opening is taken to consist of the time between the moment when co-
presence is established and the time when participants orient to the commencement of 
‘business’, when their focus turns to the medical issues of the consultation, usually 
with production of an ‘opening elicitor’ such as ‘How are 
you/going/today?’, ‘How’s the pain?’.

Closings. A closing is taken to be the time between when pre-closing actions are 
taken up and co-presence is broken, when the medical team leaves the interaction 
space.

Consultation core. The consultation core is that part of the consultation that covers 
when participants are occupied with the main medical business of the consultation. 
The consultation core occupies the period between the ‘turn to business’ usually 
displayed by production of an ‘opening elicitor’ (see above), and the beginning of the
closing. An example of a consultation core is seen in Extract 21 (§4.2.2.2), which deals with the overall structural organization of the consultation includes the consultation core, which is represented between lines 9 and 232.

Within the overall structure of the consultation, I focused on activities that seemed to be unique to this setting. For this reason, I collected examples of the following activities that appear to be unique to this clinical setting. I

**Greeting sequences.** These sequences may or may not be ‘complete’ (i.e. a SPP does not invariably follow a FPP). They comprise the following: ‘Hello’, ‘hi,’ ‘g’day,’ ‘good morning/afternoon’
Initiator: Doctor, patient

**Introductions.** Two types of introductions occurred in this data. They were: Two-party self-introductions, and three-party mediator introductions. Extracts showing introductions can be found in this section, for example Extract 38, §5.3.4.1 (also Extracts 30-41, §5.3.4.2).

**Case presentations.** These involve the presentation of clinically pertinent facts about a patient’s condition and history. Three sub-types of case presentation were identified: the ‘Demonstration Case Presentation’ (led by a senior doctor), the ‘Candida Case Presentation’ (led by a junior doctor) and the ‘Peer Case Presentation’ (presented by and to senior doctors) (for example Extract 44, §5.3.6.1).

**Discharge planning.** These are discussions between doctor and patient about proposed discharge arrangements and are themselves discussed in Chapter 6. A transcript of a discharge planning discussion can be seen in Extract 61 (§6.3.5).

**Specialist Feedback Request (SFR).** This is another particular kind of feedback request that occurs during the consultation core, where the doctor asks the patient whether a particular specialist (who is not currently present) has visited the patient. If so, there is usually an expansion of this request, to report what the specialist has said.
Structurally this is a question + request sequence. An example of an SFR can be seen in Extract 53 (§6.3.2.2).

**Procedure Feedback Request (PFR).** This is a particular kind of feedback request that can occur during the consultation core. It is similar to the SFR described above, except the subject of the doctor’s question and request is procedures that have been ordered. The doctor asks the patient whether a particular procedure has been accomplished yet and if so, what its results were. A transcript of a PFR can be seen in Extract 56 (§6.3.2.3).

**Settling in and registering.** This is an activity that displays an orientation to identifying experiences in common during the opening. A transcript of an episode of registering can be seen in Extract 37 (§5.3.3.1).

**Thank you sequences.** These are discussed in Chapter 8, and consist of a complete or (often, in this data) incomplete AP consisting of A: Thank-you, B: That’s fine/You’re welcome etc. A transcript of a thank-you sequence can be seen in Extract 66 (§7.3.2.1).

**Pleasantries.** These consist of ‘light banter’ or ‘small talk,’ commonly during the consultation pre-closing or final closing. A transcript of an exchange of pleasantries can be seen in Extract 68 (§7.3.2.2).

**Address terms.** These can take the form: No name, first name, title + surname (‘Mr Jones’), ‘Sir’, role title (‘Doctor’) Sequence: Doctor-patient, Patient-doctor

### 3.8.4 Quantitative analysis

This section outlines the use of quantitative analysis used in this study. The process followed in analyzing frequency data is outlined in §3.8.4.1, before the ‘things’ that were counted are listed and defined, and the reasons for counting them outlined in §3.8.4.2.
Basic quantitative analysis supplemented the main CA analysis by providing a general overview of different aspects of the consultation as seen in this data, as well as locating points of possible contrast with features described in consultations in other clinical settings. Frequency counting was sufficient to provide this general overview. It was used to investigate selected features of interaction in the data (such as the format of opening elicitors or address formulations) as well as some ethnographic information (such as the duration of different phases of the consultation) (see also §3.7).

It is not possible for complex statistical analysis to be performed on the features that were counted in this study because the data set was too small. Frequency counts in this study therefore refer only to this particular data set and they have no capacity to be extrapolated further.

Frequency counts of selected phenomena allowed me to present “a basic observation of what most of the instances do” (Stivers, 2015:15) in this data in a similar way that CA analysis routinely includes reference to “quantifying expressions” (ten Have, 2007:158), as discussed earlier in §3.2.1. This helped provide a general background for the main CA analysis. In this way it supported the study aims to (1) describe the bedside consultation and (2) find evidence of whether the bedside consultation was distinctive compared with other kinds of consultation, and if so, how.

Frequency counts were used to examine the distribution and occurrence of phenomena contained in the interaction data, such as question and answer types, locations and purposes (Stivers, 2010), as the location of various activities within consultation phases, and ethnographic dimensions of the data such as the duration of consultations and of their constituent phases.

Frequency counts are a simple form of quantitative analysis that provide limited information about phenomena of interest. Frequency counts simply involve counting selected items. In this study, structural and interactional features of the consultation were identified, defined (see §4.8.1.2 below) and counted. These included: turns taken (by doctors and patients; activities (e.g. in openings), case presentations, duration of overall consultation and consultation phases, opening elicitors and opening elicitor
formats, greeting, howareyou and address formats, final concern elicitations and responses, subsidiary components of some activities, question design and function.

Quantitatively analyzed features fell into three broad categories: These that were related to speaker role or effect of interactional features, those features that were activities or features of activities (such as the sequential location of the activity), and finally, those features that related directly to action or turn design or sequential location.

The first group of ethnographic/interactional features included: consultation duration (and the duration of individual consultation phases), themes of talk (during registering), distribution of questioners, and the actions accomplished by questions. The second group of ‘bigger picture’ structural features included: Activities occurring in each of the three major consultation phases I identified (the opening, closing and consultation core), as well as sequential location of case presentations (one of the activities unique to this setting) as well as the components of arrangement-making during the (pre-) closing.

The final group of features I counted was the ‘smaller scale’ interactional features that I could either compare in terms of frequency of occurrence and format with previous findings (opening elicitors and possibly address terms), also features (such as ‘howareyou’ sequences) which I could compare in terms of occurrence between different kinds of bedside consultation (e.g. changeover v. regular).

3.8.4.1 The process of the quantitative analysis

The process of collecting and analyzing items for frequency counts was straightforward. I located selected phenomena in the consultation transcripts and entered them manually into Excel tables. Excel allowed me to reliably calculate totals and percentages, and it also allowed me to present results in graphs or charts which could be imported into the thesis document where required.

Excel had the flexibility to include single or multiple frequency calculations on a single worksheet. For example, I could estimate the distribution of a particular
phenomenon (e.g. initiating a turn at talk) against a variable such as speaker category (e.g. doctor, patient or ‘other’) at a particular phase of the consultation (e.g. the consultation core), or I could plot out the occurrence of a range of features such different activities (e.g. opening activities such as howareyous, greetings, introductions, case presentations, registering/settling in) in the opening phase of all the consultations in the data set.

### 3.8.4.2 Ethnographic and interactional features that were counted

Before discussing what ‘things’ I counted, I outline the general motivations for the categories counted. The interactional and ethnographic features analysed quantitatively in this study are shown in Table 3-1 and were analysed within a framework of a multi-field approach to the investigation of the organization of social action (discussed in Goodwin, 2007 and Antaki, 2011). They were chosen on the basis of their capacity to contextualize qualitative analysis (such as the duration of different phases of the consultation as well as the consultation as a whole), to provide the means for indicative comparison with prior research into similar phenomena in other clinical or social settings (such as the formats of opening elicitors, Table 6-2), to illustrate key interactional dynamics (such as the distribution of questioners through the consultation, Table 7-1) or to elaborate qualitative CA analysis of particular practices or activities (such as the sequential location of case presentations, Table 5-4).

A key motivation in my use of frequency counts was to support the study objective to describe the bedside consultation, based on its data set. This involved describing the consultation from a ‘big picture’ structural perspective, viewing the consultation as a whole event and describing its main structural components (‘phases’) and as a series of smaller sub-sections (‘phases’) themselves made up of a series of smaller sub-sections (activities).

A second key aim in my use of frequency data was to point to areas of possible comparison with findings about similar features in other types of medical consultation. The motivation underpinning my choice of features to count was related to my interest in establishing whether, and if so, how the bedside consultation was unique or distinctive compared with other kinds of consultation. With this aim in mind, I chose
some interactional features to count that could be compared with similar quantitatively derived findings in other settings reported in the literature.

The features that I counted, the location of this analysis and associated CA research (if any) are shown in Table 3-1 below, and descriptions of each counted feature are listed below the table.
The ethnographic and interactional phenomena (‘things) that were counted to help provide a general background to the CA analysis of the consultation in this study are outlined below. These phenomena are discussed in Chapters 4 – 7, and the frequency counts structure at these different levels (Chapters 4-7), as well as to identify possible

<table>
<thead>
<tr>
<th>Feature</th>
<th>Location in the thesis</th>
<th>Source in CA literature (i.e., of a comparative study)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Turn distribution through the consultation</td>
<td>Table 4-1</td>
<td>n/a</td>
</tr>
<tr>
<td>Duration of consultation phases and the consultation as a whole</td>
<td>Figure 7</td>
<td>n/a</td>
</tr>
<tr>
<td>Opening activities</td>
<td>Table 5-2</td>
<td>n/a</td>
</tr>
<tr>
<td>Activities in consultation core</td>
<td>Table 6-1</td>
<td>n/a</td>
</tr>
<tr>
<td>Final closing activities</td>
<td>Table 7-4</td>
<td>n/a</td>
</tr>
<tr>
<td>Address terms</td>
<td>Table 5-3</td>
<td>West (1984)</td>
</tr>
<tr>
<td>Components of pre-closing arrangement making</td>
<td>Table 7-3</td>
<td>n/a</td>
</tr>
<tr>
<td>Opening elicitors</td>
<td>Table 6-3</td>
<td>Robinson (2006)</td>
</tr>
<tr>
<td>Formats of follow-up elicitors</td>
<td>Table 6-4</td>
<td>n/a</td>
</tr>
<tr>
<td>Themes of ‘registering’ talk</td>
<td>Figure 17</td>
<td>n/a</td>
</tr>
<tr>
<td>Occurrence of howareyou sequences in changeovers v regular consults</td>
<td>Table 5-1</td>
<td>n/a</td>
</tr>
<tr>
<td>Sequential location of the case presentation</td>
<td>5-4</td>
<td>n/a</td>
</tr>
<tr>
<td>Distribution of questioners through the consultation phases</td>
<td>7-1</td>
<td>n/a</td>
</tr>
<tr>
<td>Configuration of terminal sequences</td>
<td>7-5</td>
<td>n/a</td>
</tr>
<tr>
<td>Questions and question design in closings</td>
<td>Figure 33</td>
<td>Stivers &amp; Enfield (2010)</td>
</tr>
<tr>
<td>Actions accomplished by questions in closings</td>
<td>Figure 34</td>
<td>Stivers &amp; Enfield (2010)</td>
</tr>
<tr>
<td>Pre-closing activities</td>
<td>Table 7-2</td>
<td>n/a</td>
</tr>
<tr>
<td>Pre-closing arrangement activities</td>
<td>Table 7-3</td>
<td>n/a</td>
</tr>
</tbody>
</table>
points of future comparison with findings regarding consultations in other settings, I counted the ‘things’ listed below.

These items were mostly taken from the CA collections described above. The aim of including frequency counting in this study was to supplement the CA analysis of the activities and organization of the bedside consultation in this data by providing a general background. It can do this by giving more concrete form to CA-type descriptors of how often something tended to occur during the consultation (in this study) or during part of the consultation. For this reason, the sole inclusion criterion for items counted was involvement in the consultation.

My definitions of the items counted are as precise as I can make them, given the fact that most of them are CA-analysed interactional phenomena. I acknowledge that coding precision (and the concept of coding) is a key problem with including quantification in CA research, however this limitation is clearly acknowledged. This material is here because I believe notwithstanding the difficulties, that it has the capacity to contribute to the ‘portrait’ of the consultation that I aim to produce.

**Consultation duration.** This was the time between the arrival of the first member of the medical team in the consultation space (establishment of co-presence at the bedside) and the breaking of co-presence at the end of the consultation (departure of the last team member).

**Opening duration:** From the establishment of co-presence at the bedside to the end of the turn preceding the opening elicitation.

**Consultation core duration.** From the beginning of the opening elicitation to the end of the turn preceding the initiation of the pre-closing action that is followed by closing activities.

**Closing duration.** From the beginning of the pre-closing action that is followed by closing activities to the moment when co-presence is broken (when the last member of the medical team leaves the interaction space).
**Turn-at-talk (or ‘turn’).** An action that is accomplished by speech with or without additional embodied resources. A turn is (1) usually responded to by a recipient in interaction with a subsequent turn and is (2) (usually) uttered in response to a prior turn.

**CONSULTATION OPENING.** The opening is taken to consist of the time between the moment when co-presence is established and the time when participants orient to the commencement of ‘business’, when their focus turns to the medical issues of the consultation, usually with production of an ‘opening elicitor’ such as ‘How are you/going/today?’, ‘How’s the pain?’.

**Opening activities:**

*Greeting sequences:* Form: ‘Hello’, ‘hi’, ‘g’day,’ ‘good morning/afternoon’.

These sequences are not always reciprocated, that is, a FPP does not always elicit a SPP. Initiator: Doctor, patient

*Registering* This is an activity that displays an orientation to identifying experiences in common during the opening. A transcript of an episode of registering can be seen in Extract 37 (§5.3.3.1). Forms of registering action: Declarative tag question (e.g. ‘You’d think it was Paul Hogan, wouldn’t you?’), polar question, declarative statement. Themes of ‘registering talk’: These include: the hospital, the weather, this research study, being filmed, the hospital routine, the doctors, that patient. Initiator: doctor, patient.

*How are you sequences.* They are a type of adjacency pair with the first pair part consisting of: A: ‘How are you?’ and the second pair part consisting of a range of possible responses including B: ‘Fine/okay/well/very well/not well [thank you].’

*The case presentation.* (e.g. Extract 44, §5.3.6.1). The case presentation is where the clinically pertinent facts are presented to the medical team. Three sub-types of case
presentation were identified in the study but for the purposes of this frequency count, all types were categorized simply as ‘a case presentation.’

Formulation of address terms used in openings:

*Address terms:* These can take the form: No name, first name, title + surname (‘Mr Jones’), ‘Sir’, role title (‘Doctor’)

Sequence: Doctor-patient, Patient-doctor

**CONSULTATION CORE.** The consultation core is that part of the consultation that covers the main medical business of the consultation. The consultation core occupies the period between the ‘turn to business’ usually displayed by production of an ‘opening elicitor’ (see above), and the beginning of the closing. An example of a consultation core is seen in Extract 21 (§4.2.2.2), which deals with the overall structural organization of the consultation includes the consultation core, which is represented between lines 9 and 232.

**Activities in the consultation core:**

*Opening elicitation.* This initiates the medical business of the consultation and commonly takes the following forms in this data:

‘How are you (today/this morning/Mrs Jones)?’
‘How are you feeling (today/this morning/Mrs Jones)?’
‘How are you doing/going (today/this morning/Mrs Jones)?’
‘How’s your pain/foot (symptom)?’
‘So you had your skin graft (procedure) last night?’

*Introduction*  Two types of introductions occurred in this data. They were: Two-party self-introductions, and three-party mediator introductions. Extracts showing introductions can be found in this section, for example Extract 38, §5.3.4.1 (also Extracts 30-41, §5.3.4.2).

*Case presentation* (see above. This can occur in either opening or consultation core.)

*Specialist Feedback Request*  This is another particular kind of feedback request that occurs during the consultation core, where the doctor asks the patient whether a particular specialist (who is not currently present) has visited the patient. If so, there is
usually an expansion of this request, to report what the specialist has said. Structurally this is a question + request sequence. An example of an SFR can be seen in Extract 53 (§6.3.2.2).

Procedure Feedback Request This is a particular kind of feedback request that can occur during the consultation core. It is similar to the SFR described above, except the subject of the doctor’s question and request is procedures that have been ordered. The doctor asks the patient whether a particular procedure has been accomplished yet and if so, what its results were. A transcript of a PFR can be seen in Extract 56 (§6.3.2.3).

History taking/verbal examination. This is an activity where the doctor elicits information from the patient about his or her symptoms to help assess his/her condition. It is generally a question and answer sequence and it is not a particular focus of this study.

Diagnosis/appraising current diagnosis. This is when the doctor gives the patient an assessment of his or her current condition. For example: D: ‘You’ve got a tremor (.) often experienced when you’re older’

Treatment/affirming current treatment recommendations. These are discussions where the doctor makes recommendations about treatment for the patient, in this data it usually involves confirming the continuing of existing treatment regimes. Patients usually accept doctors’ recommendations, and sometimes ask questions about it. An example of a complex treatment discussion is seen in §6.3.4.

Discharge planning. This takes the form of discussions between doctor and patient about proposed discharge arrangements and are themselves discussed in Chapter 6. A transcript of a discharge discussion can be seen in Extract 61, §6.3.5.

CLOSINGS. A closing is taken to be the time between when pre-closing actions are taken up and co-presence is broken, when the medical team leaves the interaction space.
Components of pre-closing arrangement making:
Arranging surgery, Referring back, Referring on, Arranging diagnostic testing, Organizing follow-up, Issuing instruction about paperwork, Arranging discharge, Doctor offering future accessibility, (Re-) affirming treatment plan, Referring to pending test results, Referring to follow-up, ‘See you tomorrow’/at a particular later time, Organizing the removal of medical appliances (e.g. ‘bungs’), Promise of administrative follow-up on patient’s behalf, Patient request for information/confirmation of arrangements, Patient re-iteration of prior request. I was interested in counting these ‘things’ (1) to give an overview of what arrangement making ‘looked’ like in my data and (2) to be able to compare it with what had been described in this regard in the setting of the surgeon visits (White, 2011).

Final closing activities:
These can be:

Thank-you sequences. These are often unreciprocated in this data, but a complete thank you sequence would be: A: ‘thank you’, B: ‘it’s a pleasure.’

Leave-taking. This may or may not be reciprocated and usually take the forms of: ‘Bye’/’bye’ or ‘good bye’/’good bye.’

Pleasantries. Items of ‘small talk’ prior to leave-taking. For example: ‘I’ll pass you [in the passage] maybe.’

Composition of terminal sequences.
Thank-you only
Farewell/terminal exchange (complete or partial i.e. FPP only)
Pleasantries only
No farewell/terminal action (only breaking co-presence)
Thank you + farewell/terminal exchange
Thank-you + pleasantries
Farewell/terminal exchange + pleasantries
Thank-you + farewell/terminal exchange + pleasantries

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QUESTION SEQUENCES: Discussed in Chapter 7 and Chapter 3 examples can be seen in. Extract 19.

Question design. Figure 33. The protocol outlined by Stivers & Enfield (2010) was used. Question designs include: Polar (e.g. ‘Are you feeling better today?’), ‘Content’ or ‘Q’ (e.g. ‘How are you?’), and Alternative (e.g. ‘Would you like your coffee black or white?’).

Actions accomplished by questions. The protocol outlined by Stivers & Enfield (2010) was used. These can be:

- Information request, e.g. ‘Has Dr Jones been to see you?’
- Request for confirmation, for example: ‘You are having your procedure this afternoon, aren’t you?’
- ‘outloud’ e.g. ‘Wouldn’t you know?’.

These are exemplified by Stivers and Enfield (2010).

Questioners. There were two possible categories of questioner: Doctor and patient. Reason for analysis: question sequences are a powerful and versatile form of initiating action, and they are a well-documented feature of medical discourse. A robust coding system has been devised for documenting the use of questions in interaction (Stivers & Enfield, 2010), making it possible to code and count aspects of questioning. Questioners have the opportunity to direct interaction while question recipients have the opportunity to exert agency and resist the inbuilt constraints of the questions or to comply with them. For this reason, they are an interesting focus for attention.

Reason for analysis: question sequences are a powerful and versatile form of initiating action in interaction, and they are a well-documented feature of medical discourse. A robust coding system has been devised for documenting the use of questions in interaction (Stivers & Enfield, 2010), making it possible to code and count aspects of questioning.
3.8.5 Integrating qualitative (CA) and quantitative analyses

The process of integrating and combining the qualitative CA and quantitative analysis was iterative. During the process of examining and developing CA transcripts and collections described above (§3.8.4.1) and my sense of the organizational structure of the consultations strengthened, I periodically became curious about what patterns might exist in the data. What patterns might there be in the activities occurring in particular consultation phase throughout the consultation? Conversely, do particular activities always occur in the same part of the consultation?

For example, what is the organizational ‘shape’ of the consultation core? Is there much variation in activities occurring during the consultation core across the data? Or how often do case presentations occur, and when they do occur, where (in the consultation) do they occur? In the opening? In the core? What might their position in the consultation show about the kind of activity participants treated this as being? (How) do greeting formulations vary across consultations?

The answers to these questions could be found by simple counting, provided the phenomena being investigated could be sufficiently well defined. These answers helped provide a general overview of aspects of the data which could then be further investigated using case-by-case detailed CA analysis. In fact, as mentioned earlier (§3.8.4.2) CA analysts traditionally use similarly quantitative terms and practices to order and describe their findings.

The process of exploring this data therefore cycled between qualitative CA investigation and basic quantitative analyses, albeit with CA being the predominant method and ‘counting’ supplementary. These two approaches fed into and supported each other in an iterative manner as I worked towards improving my understanding of the data and building a progressively more detailed ‘picture’ of the consultation using the methods described in §3.8.4.1 and §3.8.4.2.

3.9 Summary and next chapter

This chapter has outlined the design and methodology of this study. The data and participants were described, ethical parameters discussed, data collection methods...
described, and software used described. Three key aspects of the methodology used to analyze the data were also outlined (and illustrated where relevant with examples from the data), namely transcription, quantitative and qualitative analysis (CA), as well as discussion of the rationale for choosing the study’s design and analytic approach.

In this chapter, I described how I combined qualitative CA analysis with simple quantitative analysis to provide a CA analysis of the interactional data supported by general background information derived from interactional data and some ethnographic data. I contextualized my decision to incorporate limited ethnographic data and quantification within past and current practice in CA. The limited use of mixed analytic methodologies has been evident in the literature for some time. The combination of quantification and CA analysis is being discussed increasingly in the CA literature, and this analytic approach is becoming increasingly prevalent, particularly in the area of ‘applied CA’, which generally focuses on institutional interaction, including medical interaction.

Overall, in this chapter I described different aspects of the research design of this study, and explained how I collected, examined, organized, and analysed the complex interactional consultation data in my study so that I could address the RQs that shape this research.
Chapter 4 Overall structural organization of the bedside consultation

4.1 Introduction

This chapter presents an overview of the bedside consultation in the adult medical ward context, focusing on its overall organizational structure but also describing consultation types, participants, duration and context within the ward round visit. As mentioned in Chapter 3, these consultations involve adult medicine practiced in an Australian tertiary teaching hospital.

The chapter offers an account of the organizational framework that participants appear to orient to in conducting the bedside consultation. In so doing, it aims to provide a contextual framework for discussions of component phases and activities of the bedside consultation in Chapters 5-7. Together this and later results chapters together describe the organization and conduct of the bedside consultation based on the data in this study. This description can be compared with what is known about medical consultations in other clinical settings, and thereby respond to key questions of the thesis: how is the bedside consultation organized and conducted? Is it distinctive, and if so how, and why?

We therefore now turn to the first research question of the thesis:

RQ1 What is the overall structural organization of the bedside consultation?

In this section I outline the contents of this chapter.

4.1.1 Chapter outline

Following an overview of the overall structural organization of the consultation as a whole, later chapters (Chapters 5-7) explore and describe the lower-level organization and turn-by-turn organization of the consultation.

There are two sections of background information about the daily ward round (§4.2) and the bedside consultation (§4.3) before an analysis of an entire consultation from the data is analyzed in (§4.4).
Background information about the ward round covers types of ward round visit (§4.2.1), participants (§4.2.2) and its overall structural organization (§4.2.3). Similarly, types of bedside consultation are discussed (§4.3.1), as is the duration of the consultation (§4.3.2) and the distribution of speaking turns through the consultation (§4.3.3).

The overall structural organization of the bedside consultation (based on this data) is shown in (§4.4.1), as is the internal consultation structure for both the bedside consultation in general (based on this data set) and of the ‘sample’ consultation that is analyzed in particular is shown in §4.4.2. The sample consultation is then introduced (§4.4.3) and analyzed (§4.4.3.2 – §4.4.3.4).

background. Its duration (§4.3.1), the distribution of speaking turns between participants (§4.3.2), its overall structural organization (§4.3.3) and its internal organizational structure are outlined (§4.3.4) before the analysis of an entire transcript of a consultation from this data is presented.

In §4.4, a sample transcript from the study data is introduced (§4.4.1) and it is subsequently analyzed in §4.4.3 to illustrate and exemplify the structural features of the consultation. The full transcript is shown in Appendix 6 as it is intended to illustrate the general ‘shape’ of the bedside consultation in terms of its component activities and sections, and to exemplify points through the consultation where participants can be seen to be orienting to the overall organizational structure.

After a brief background of the selected consultation (§4.3.3.1), each of the three key phases of the consultation are discussed in §4.3.3.3 - §4.3.3.5. The internal structure of the consultation is outlined in §4.3.3, the different types of bedside consultation in this data are outlined in §4.3.4.

The chapter ends with a brief summary of the chapter findings in §4.5.
4.1.2 Overall structural organization

The term ‘overall structural organization’ refers to an order of interactional organization that is central to the analysis of data in this study (discussed in §3.8.3). It is the kind of organization people use in interaction to meaningfully arrange the things that can be talked about on that occasion. Schegloff & Sacks (1972) describe this as the “considerations relevant for conversationalists in ordering and distributing their talk about mentionables [things that can be talked about] in a single conversation” (Schegloff & Sacks, 1972:292). Overall structural organization is, therefore, the order of organization that participants in interaction use to manage the composition and sequencing of activities they co-construct in that interaction. It is discussed in detail in Chapter 2 and is the focus of this chapter.

4.2 The daily ward round visit

The daily ward round is the context for the bedside consultation. As noted in Chapter 2, the daily ward round visit is a central component of inpatient hospital care, both structurally and in terms of content. As such it is an important part of the hospital routine, which is its broader institutional context.

4.2.1 Types of ward round visit and their work

As mentioned in §3.3.1, there are two types of ward round visit in this study: regular visits and changeover visit. There is no standard terminology for different ward round types, as discussed in §2.2.4

4.2.2 Participants in the ward round visit

The ward round visit in this hospital was an event managed by the medical participants as they visited their patients. A representation of the ward round visit structure is shown below (§4.2.3), where it can be seen that the bedside consultation is a visit within a visit. At the bedside, the patient is present as well as the doctors and other medical staff, as well, occasionally as family members of the patient.

The number and type of participants in the ward round visit varied according to the type of visit being undertaken, and (when concerning family members), chance. All
visits involved patients at the bedside consultation, and family members were also occasionally present at the bedside, although there was never more than one family member present in this data. Family members who were present during consultations in this study were patients’ wives (on three occasions – C44, C36, C10) and daughters (on three occasions – C22, C38, C45) and one patient’s son (C25). Allied medical or other staff seldom attended these consultations. The size of the medical teams in this study varied between consultations, and the number of medical participants ranged between two (e.g. C15) and eight (e.g. C47).

4.2.3 Overall structural organization of the ward round visit

Overall structural organization of an interaction provides the means for participants to sequence and position component activities in relation to each other. There is a long history of investigation into the issues of how the medical consultation is structured, and into how its overall structural organization is managed across a range of community medical settings, beginning with Byrne and Long (1976), continuing through to more recent scholars such as Robinson (1998; 2003), Heritage and Maynard (2006), White (2011) and Paul (2015). Heritage (1997:227) recommends mapping the ‘shape’ of the medical consultation in terms of its “typical ‘phases’ or ‘sections’”. In a hospital setting, in particular during a ward round visit, the organizational structure of the ward round visit depends on the number of doctors who are present. This is because different tasks become relevant when a medical team rather than a single doctor is present.

The ward round visit incorporates a managerial and coordinating element lacking in the bedside consultation. The bedside consultation accommodates the clinical, educational and associated interactional work of the doctor/s visiting the patient at the bedside to assess his/her condition etc. while the ward round visit includes the bedside consultation and bookends it with preparatory and post-consultation coordinating discussions between members of the medical team.

The number of medical participants also has an important impact on the overall structural organization of the ward round visit. When a ward round visit is conducted by a multi-party medical team, activities not needed when a sole doctor
officiates become relevant, including pre- and post- bedside corridor discussions between team members outlining the relevant issues pertaining to the patient to be visited, and (at the bedside) multi-party introductions, and case presentations. When a ward round visit is conducted by a single doctor, such as when a specialist surgeon visits a patient post-operatively to check on their progress, the ward round visit and the bedside consultation are one and the same encounter, as the ward round visit occurs at the bedside. On these occasions, there is effectively only a bedside consultation.

Not only does this mean that additional activities characterized the team-led consultation that are absent during single-doctor led consultations, but also that entire phases that invariably characterized the team ward round visit were absent during the sole-doctor ward round visit (notably the pre- and post- bedside consultation discussions, but also case presentations). All ward round visits in this study were conducted by a medical team, as discussed in §4.2 above.

When a medical team conducts the ward round visit, its size varies depending on the type of consultation underway to accommodate the particular constraints and objectives of each. The numbers of participants attending regular and changeover consultations varied, and also consultations within a consultation type (sometimes not all team members are present, so a subset of the team conducts the visit, e.g. C11). This latter variation in team size is particularly apparent in regular consultations, where sometimes there are only two doctors in the team (although there may be up to eight, including students). Regardless of the number of team members, the ward round visit as a whole retains the same structure throughout the study data.

‘The ward round visit’ henceforth refers to a team visit. The following description of how the ward round visit unfolds, based on this study data, situates the bedside consultation in the broader context of the visit type of which it is a part, albeit a focal part. The structural organization of the bedside consultation as a whole is described in §4.3 (below), and this description is illustrated with the transcript of an entire consultation from the study data (C48). Components of the bedside consultation structure are discussed in more detail in following chapters (Chapters 5 - 7).
The structural organization of the team ward round visit is distinguished by phases that occur either side of the bedside consultation. The overall structure of the complete ward round visit is shown diagrammatically, in Figure 6 below.

**Figure 6  The overall structural organization of the ward round visit**

Figure 6 shows how the ward round visit is accomplished through three phases. The first phase occurs in the corridor outside the patient’s room (regardless of whether the room is a single bed- or shared ward), as does the final phase when members of the team finalize task allocation and other arrangements made during the bedside consultation.

In the pre-consultation briefing, medical team members gather around the trolley containing patient records and a laptop computer used to document or update the records, to prepare for the bedside visit out of earshot of the patient. This preparatory meeting occurs before each bedside consultation. Similarly, after completion of the bedside consultation the medical team generally reconvenes outside the ward to summarize and discuss outcomes of the consultation and confirm and allocate emergent tasks and other actions. The bedside consultation occurs *after* the preparatory briefing between the medical staff, and *before* the post-consultation summary discussion of consultation outcomes between members of the medical team.

The bedside consultation is the central component of the team ward round visit. The purposes of the ward round are varied, but chiefly revolve around visiting each patient on the treating ‘list’ to assess their medical condition and progress. The bulk of the clinical work of the ward round, and much of its administrative work is done at the
bedside, and how this plays out in this data this is discussed in more detail in following sections and chapters.

Participants in this study treat the three-part organizational structure shown in Figure 6 above for the ward round visit as normative. Only the bedside consultation is videotaped and otherwise examined in this study, but future research could examine how different parts of the overall visit are conducted, and how they are linked.

4.3 The bedside consultation

4.3.1 Types of bedside consultation and their work

Bedside consultation type can be classified in two ways in this particular hospital setting. First, the type of medical consultation it is, and second the kind of consultation it is in terms of the institutional routine of the hospital.

As a type of medical consultation, the bedside consultation is invariably a follow-up consultation, because for the patient to have been admitted to hospital, he or she must have received a diagnosis in a prior consultation on admission. As a type of consultation in the context of the hospital routine of this particular hospital, and (as mentioned in §4.3.1) using terminology used by the participants themselves, the bedside consultation can be either a regular consultation (held Monday to Thursday) or a changeover consultation (held Friday). The work associated with each of the abovementioned types of consultation varies yet intersects uniquely in this kind of consultation.

Hospital admission presupposes initial patient assessment and differential or provisional diagnosis having occurred during some initial ‘first visit’. The patient’s initial diagnosis may have been made on the basis of results of examinations and tests given or ordered, and sometimes these medical issues are still under investigation at the time of the bedside consultation. The bedside consultation is therefore never an initial consultation in the sense that first consultations in outpatient settings described in the literature, are (Byrne & Long, 1976; Heritage & Maynard, 2006). The follow-up medical consultation itself is a relatively little understood type of consultation compared with initial consultations, and as previously noted, most of the existing
literature deals with consultations occurring in community or outpatient settings, such as with general practitioners, or specialists such as surgeons, or psychotherapists (White, 2011; ten Have, 1999; teas Gill & Maynard, 2006; Robinson, 1999; 2003; Heritage & Robinson, 2006; Halkowski, 1999, 2006). This study therefore contributes to our understanding of how this work is done, in an inpatient hospital setting.

In addition to the work of the follow-up consultation, participants in the bedside consultation conduct work that satisfies several institutional agendas. These are chiefly administrative, educational and clinical. The administrative responsibilities include record-keeping, the transfer of responsibility for patient care from one medical team to another at the end of each week-long roster period (‘changeover’). The educational agenda centres on providing on-the-job clinical training for junior doctors and medical students, while the clinical agenda coincides with that of the follow-up consultation as is focused on provision of medical care for the patient with all its associated ‘pastoral’ dimensions, chiefly providing the emotional support that is embedded in good clinical care.

The work of the bedside consultation involves participants in different ways. Doctors (as medical professionals) and patients work together to conduct clinical work of the consultation. Doctors (as agents of the hospital) maintain records and collect information about clinical actions taken and agreed upon during consultations to maintain hospital records and also to compile statistics. In this capacity, they also fulfill educational responsibilities in relation to associated joint hospital-university and professional medical training programs.

Senior doctors (in their joint capacity as hospital employees and agents, and also as experienced clinicians) supervise clinical training for junior doctors and medical students as part of the formal training program jointly run by a local university medical school and the hospital. Junior doctors and medical students engage with the clinical experience of participating in a ward round to learn, demonstrate their clinical and relational skills and understanding and seek clarification where needed. Senior doctors work to socialize junior doctors, medical students and also patients into the routines
and practices of the bedside consultation and hospital routines in what can be understood to be ‘professional socialization’ (Duranti, Ochs & Schiffelin, 2014). Patients not only participate in the clinical and educational work of the doctors, but also advocate for themselves when they have questions, uncertainty and concerns they want addressed by their doctors.

From the perspective of the patient, the bedside consultation provides the opportunity to work with the doctors in the medical team to accomplish the clinical and administrative work outlined above. Patients also work with the medical team to facilitate the educational and professional socialization aspects of the work outlined above, namely the clinical education and socialization of medical students and junior doctors. Patients have their own agendas to pursue in the consultation beyond helping medical team achieve their professional objectives and obligations, as well as the institutional administrative work of the consultation. The consultation potentially offers patients the opportunity to voice their concerns, elicit information about matters they do not understand, and on occasions to pursue agendas that may conflict with those of the medical team (such as expediting or delaying discharge from hospital). It also represents a chance to seek reassurance about their symptoms or condition, and forge or strengthen social links with members of the medical team.

4.3.2 Duration of the bedside consultation

The bedside consultation is relatively brief. The average duration of bedside consultations in this study is four minutes, 57 seconds, or approximately five minutes. This represents a range from one-and-a half minutes (99 seconds) to ten-and-a-half minutes (638 seconds). This is longer than the duration of New Zealand bedside consultations reported in the literature (Creamer et al., 2010). In that study, the duration of bedside consultation varied from one minute, 50 seconds to two minutes, 30 seconds, depending on the location and type of the wards being visited (i.e. ‘home wards’, acute wards and outliers). In this study all wards are ‘home wards’ for the medical teams. That is, all patients are in general medical wards, which are the ‘home wards’ for the team involved in the study.
Although Creamer et al (2010) document the duration of the bedside consultation as a whole, there is no information about the duration of its component parts. In this study, average time spent during different phases of the consultation are shown in Figure 10.

![Figure 7: The duration of consultation stages](image)

The opening and closing sections are brief, together comprising an average of 10% of the entire consultation. This leaves 90% of the consultation for the consultation core, or the ‘business’ section of the encounter, when most of the medical, clinical work of the consultation is done. This is when the doctor works to assess the patient’s condition and progress since the last consultation, and thereby also tests the validity of the current diagnosis through verbal and physical examination. From this point s/he decides whether to confirm or change the diagnosis, and on the basis of that decision proposes a treatment and care plan and discusses discharge planning and next steps with the patient. The opening and closing sections of the bedside consultation are generally brief but are times when important administrative and pastoral work is done, sometimes through structurally complex sets of actions and activities.

As noted above (§4.3.1 and through §4.3.3) the brevity of both the consultation as a whole and of each of the component phases is notable because of the amount of work that is achieved within each of those units. Creamer et al (2010)’s results suggest that this brevity (and more) may not be unusual at the bedside, however it shows
nevertheless how efficient conduct of clinical care in this setting is (or can be) in this particular hospital and data set.

4.3.3 Distribution of speaking turns in different consultation phases

An additional observation about the conduct of the bedside consultation in this study involves patterns of (speaking) turn distribution between participants across the phases of the consultation. This is shown in Table 4-1 below.

Turns at talk can be viewed as currency in the economic system of the conversation, where they are opportunities to participate verbally (Sidnell, 2010; Sacks et al., 1974). In dyadic interaction, turns are by default equally distributed between the two parties. In multi-party interaction (including the bedside consultation'), conversation is nevertheless chiefly dyadic, and since (as Sacks et al., 1974 observe) one speaker speaks at a time, speaker change recurs and/or occurs, then turns are also distributed equally (between the dyad – or a dyad).

Turns at talk (see definition in §3.2.2.3) are therefore an important element of participation in interaction, along with embodied action, such as looking, smiling, frowning, eye-rolling, head shaking, gesturing etc. Elements of speaking turns such as their individual duration also contribute importantly to participation as well, as does the part the turn plays in the actions they help accomplish. For example, speaking turns that initiate new actions contribute differently to participation than responsive turns, and someone who talks a lot may dominate the interaction for a time even if they do not have many turns at talk (e.g. during a case presentation or problem presentation in a GP consultation).

I chose to focus on speaking turn distribution because of the centrality of talk in my description and analysis of the bedside consultation. This is notwithstanding the fact that embodied elements of interaction are also included and acknowledged as intrinsic to interaction in this and other contexts. I include this information as a general observation which contributes to this account by illustrating an important aspect of how the bedside consultation ‘looks’ in this data. Speaking turns were counted in 48 consultations,
Table 4-1 Distribution of speaking turns through the consultation

<table>
<thead>
<tr>
<th>Participant</th>
<th>Opening % turns (n = 401)</th>
<th>Core % turns (n=4436)</th>
<th>Closing % turns (n = 507)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctor</td>
<td>57</td>
<td>54</td>
<td>55</td>
</tr>
<tr>
<td>Patient</td>
<td>35</td>
<td>44</td>
<td>45</td>
</tr>
<tr>
<td>Other</td>
<td>8</td>
<td>2</td>
<td>0</td>
</tr>
</tbody>
</table>

The pattern of turn distribution shown in Table 4-1 may reflect the multi-party nature of the bedside consultation, where doctor-patient dyads are not the only possible combination of speakers, as much as it reflects institutionally normative patterns of interactional dominance by doctors. This emphasizes the importance of recognizing that this set of basic observations focuses on categories of participant, rather than individuals, so is not able. This also means that patients may at times be excluded during doctor-doctor exchanges as a function of the multi-participant nature of the interaction in the same way that most members of the medical team are excluded most of the time, as are family members, when present.

Doctors are particularly dominant in the opening, in terms of taking turns at talk relative to the patient and other participants (such as family members who may also be present or members of the medical team who are not doctors). This asymmetry in the distribution of speaking turns is greater in the opening than in other sections of the consultation and it may reflect the leading role played by the doctor in establishing the structural and sequential parameters of the consultation at this point and is consistent with what has been observed in institutional interaction in other settings (Drew & Heritage, 1992). It is usually the doctor who initiates greetings, orchestrates introductions and from time to time, delivers introductory case presentations. Although patients are also active participants in the consultation opening, it is generally the doctors who take the lead in the ways outlined above.

Patients take more speaking turns during the core and closing sections, possibly reflecting their more active roles during these phases participating in such activities as verbal examinations, discharge discussions, discussions about treatment and possible
follow-up plans, tests or procedures, and final questions seeking clarification of arrangements.

It is rare for family members to be present during the bedside consultation, and when they are, the core of the consultation is the part of the visit in which they play the least active part. Conversely, the consultation core is the part where patients play their most active role, on average. In other words, when family members were present, they usually play the role of members of the overhearing audience (along with the rest of the medical team) during the core business section of the consultation, generally only participating actively during the opening and closing.

4.4 How the bedside consultation is organized

4.4.1 Overall structural organization of the bedside consultation

The overall structural organization of the ward round visit is discussed above in §4.3.3. In this section, the overall structural organization of the bedside consultation is outlined. The bedside consultation is a (central) component of the ward round visit and it has its own internal structure. Participants orient to an overall structural organization outlined and exemplified in this chapter (discussed in more detail in following chapters) and illustrated in Figure 8 below.

Figure 8 The overall organizational structure of the bedside consultation (phase structure)

Figure 8 illustrates the overall structural organization of the bedside consultation as a unit of interaction. At this higher level the organizational structure of the bedside consultation is quite generic, in the sense that it can describe the organizational structure of many different medical consultation types, and if ‘core of the consultation’ is replaced with ‘core business’, it can describe the organizational structure of many diverse mundane and other institutional encounters. It is important
to emphasize that these structural phases occur in a particular normative sequential order. This means that, for example, the second (core) phase becomes relevant only after completion of the first (opening), and the final (closing) phase becomes relevant only after completion of core business.

In common with many other types of medical consultation, the sequencing of different sections, even at this higher level of organization, is frequently somewhat or highly iterative (Byrne & Long, 1976; ten Have, 1989; Robinson, 2003; Paul, 2015). This iterative character is evident in C48, the representative consultation, and this is discussed and exemplified in §4.3.3 below.

4.4.2 Internal structures of the bedside consultation

Each section or phase of the bedside consultation in this data comprises a series of activities that are themselves comprised of particular sequences of actions co-constructed by participants, following one another sequentially. This sequential progression of activities shows that participants treat activities as being relevant only after completion of particular prior activities. If the relevant prior activity or activities have not yet been completed, attempts to progress regardless are treated as premature, and the ‘proposed’ next activity is not developed. In this way, consultation participants enforce a particular sequential ordering of activities in its co-construction. This is evidence that they orient to a normative overall structural organization of the bedside consultation.

In as much as the activities participants orient to as being relevant during the bedside consultation are different from those shown to characterize other kinds of medical consultation, overall structural organization provides an insight into the unique character of this kind of encounter.

The activities comprising phases of the bedside consultation are summarized with reference to C48 in §4.3.3 below, and they are discussed in more detail in Chapters 5, 6 and 7, each of which deals with a particular section of the consultation with reference to the data set as a whole. Despite the apparent normative ordering of activities for the
consultation, there also appears to be some flexibility in this, as some activities are
treated as allowably occurring at different parts of the consultation.

The consultation opening is where participants bring their bodies, focus, and attention
into the same physical and conceptual space, and act to achieve a mutual alignment to
the work involved in conducting the consultation. At the hospital bedside, as the
consultation involves follow-up and monitoring progress, this process of mutual
alignment involves (re-) establishing the clinical relationship between the doctor/s,
patient and family member/s, if present.

The fact that the work of the bedside consultation also involves clinical education for
junior doctors and medical students, as well as supplying professional
socialization (defined in §4.3.4 below) affects the activities that are relevant at the
bedside, including during the consultation opening. The educational and socialization
dimensions of the work of the consultation extend throughout the entire encounter, and
although many of the key educational clinical tasks and associated socialization
opportunities occurred during the core of the consultation, others occurred during the
opening. Clinical education and professional socialization that occurs at the bedside is
achieved implicitly, through demonstrating the conduct and activities required to
perform relevant clinical tasks, and also overtly, through such activities as case
presentations, and including junior doctors and (to a lesser extent) students in problem-
solving discussions by the medical team. Case presentations in particular occur in
both the opening and during the consultation core in this data, and although the
numbers of case presentations is small, in this data set, they occur more often during
the opening, and for this reason they are classified as opening activities. They are
discussed in detail in §5.3.6.

Consultations in this study involve a patient (and sometimes family member) and a
medical team. The consultation is therefore a multi-party encounter, unlike other kinds
of medical consultation where the only participants are a single doctor, a patient and
possibly also a family member. One consequence of the multi-party nature of the
bedside consultation is that some activities that are not relevant in other clinical
settings are relevant here. An example of such an activity is multi-party introductions,
something more often found in social settings (Pillet-Shore, 2008) than in medical consultations (but see Paul, 2105). The multi-party nature of the bedside consultation also makes the process of the parties achieving alignment by physically and cognitively ‘coming together’ and settling in to the interaction space more complex than it would usually be in a setting with fewer participants. The structure of the consultation opening is discussed in more detail in Chapter 5, with reference to examples taken from the complete data set.

Introductions are common at the bedside, and occur in C48, that is the exemplar consultation discussed in §4.3.3. Not only does the bedside consultation involve multiple parties, but it also involves clinical training, and this makes another kind of activity relevant here that is not seen in other clinical settings: the bedside case presentation.

The consultation core corresponds with Sacks’ ‘topics’ between the (generic) opening and closing of a ‘conversation’. In all medical consultations, this is where most of the medical work of the consultation is done. This work is complex. At the inpatient bedside, this work revolves around testing and confirming, or changing, the existing diagnosis, and fitting recommendations for further investigation, treatment and future care to this conclusion. In order to test the accuracy of the current diagnosis, the doctor and medical team at the bedside in this study have to (re-) assess the patient’s condition using verbal and physical examination, assess the patient’s response to any ongoing/established treatment regime, and/or review the results of previously arranged tests or other investigations received since the last consultation. In addition to all of the above, and with reference to it, the doctor devises, explains and negotiates future treatment and care plans with the patient.

The activities and organizational structure of a particular consultation core will be discussed below in §4.3.3.4 (C48). Further examination of the core of the consultation is provided in Chapter 6 (which focuses on activities in the core section across the data set as a whole).
Consultation closing at the bedside, as with other medical (and social) encounters, involves a process of disengagement from the joint alignment required for the clinical, professional and educational tasks outlined above. Key outcomes and agreed plans of action are often reiterated, final questions elicited, asked, and answered, thanks given and acknowledged, leave-taking done, and co-presence broken. A more detailed discussion of the consultation closing is found in Chapter 7.

A summary of the organizational structure of the bedside consultation is represented in the diagram in Figure 9 below.

**Figure 9  Internal structures of the bedside consultation - phases and activities**

Figure 9 shows activities and activity sequences that characterize the three main phases of the bedside consultation, as well as their typical/normative location within those phases in this data. Not all activities occur in all consultations, nor do they necessarily occur only once. This finding is similar to what has been reported in consultations in other medical contexts (Byrne & Long, 1976; ten Have, 1989; Paul, 2015).

Those activities that do occur in the bedside consultation do not necessarily occur in the same order, or in the sequential locations as represented above. However, the
pattern, sequencing and location of activities shown in Figure 9 is sufficiently recurrent to be taken in this study as representative of, if not normative for this kind of consultation. This model is consequently presented as a prototype for this kind of consultation, based on evidence in this study.

The internal structure of the different phases of the bedside consultation can be quite complex, particularly (but not only) in the consultation core. This complexity is evident in the variable and sometimes quite highly iterative organizational structure within the framework of its simple and straightforward overall structure.

In the next section, §4.3.3, the transcript of one of the consultations in this data set (C48) is that is used as the basis for a description and analysis of the consultation as a whole is introduced. The full transcript itself is shown in Appendix 6. It contains the phases that characterize the consultations in this study, and it also contains many (although not all) of the activities that typically appear in the consultations across this data set.

In addition to this, the chosen consultation (C48) contains the iterative sequencing of activities that often occurs in consultations in this data and has been documented in consultations in other clinical settings. This sequencing pattern helps illustrate the interactional complexity of many consultations in this study. A diagram showing the structure and activities in C48 is presented below (Figure 10).
4.4.3 Sample consultation from the data

In this section, the transcript of an entire consultation, C48, which is presented in Appendix 6, is referred to and analyzed in this chapter to illustrate findings reported in §4.3.1 and §4.3.2, and also to address issues raised by the RQs in this study: What are the ‘phases’ in the bedside consultation? What activities occur during each of the component ‘phases’? What is their ‘normative order’? What activities seen at the bedside are (possibly) distinctive to this clinical setting?

The full transcript of C48 shows the complete consultation (shown in Appendix 6), which contains a number of features that characterize the encounters in this study mentioned above: namely, apparently normatively ordered consultation phases and activities, as well as an iterative activity sequencing. It also contains three atypically located activities (introductions, case presentation and addressing final questions), and illustrates two other important features of the consultations in this study: their abovementioned structural variability within a broadly normative framework, and the
necessarily provisional location of infrequent activities such as the case presentation within this framework because of the small sample size.

This transcript is intended to provide a structural overview of the consultation and to provide a ‘taste’ of the character of the consultation, showing its phases, activities and sequencing. More detailed analysis of consultation components follows in Chapters 5 – 7. These later discussions include discussion of other activities that do not occur in C48, such as specialist feedback request (SFR) and registering.

A key explaining the colour-coding used in the transcript to denote different consultation phases is presented below, as well as in Appendix 6, and discussion of the activities each phase contains are discussed below in §4.3.3.3 - §4.3.3.5. Both the consultation phases and activities relate specifically to the organizational structure and activities that I propose describes the structure of bedside consultations, based on this study data.

### 4.4.3.1 Background information about the sample consultation

This consultation (Consultation 48, henceforth: C48) was chosen because it exemplifies a number of characteristic structural and interactional features and complexities of this data (although not all, as mentioned in §4.3.3 above). It is shown in full in Appendix 6, and excerpts are reproduced in this chapter to illustrate analysis and discussion about its phases and activities.

An ethnographic note here is that although the transcript appears to be lengthy, the duration of the entire consultation is three minutes and 58 seconds, illustrating how quickly clinical care can be delivered in this context, in this data.

In C48, the female patient occupies a bed in a four-bed ward. Her bed is by the window, and there is a curtain that can be drawn around two sides of her bed to provide privacy when required. The patient is recovering from a leg infection. The consultation at the bedside occurs during a changeover ward round visit, and its participants are: the patient, two junior doctors (both registrars), two senior doctors (a consultant geriatrician and a consultant physician) and a medical student.
One of the junior doctors conducts the consultation. All the doctors are male, and the medical student is female. The two senior doctors arrive halfway through the consultation, while the junior doctor is in the process of conducting a physical examination of the patient’s leg. Towards the end of the consultation, the two senior doctors begin a parallel conversation between themselves at the same time that the junior doctor running the consultation is continuing to lead the consultation to work with the patient through the final activities of the consultation core. Because the two parallel conversations occur simultaneously in the same confined space (that is, those between the doctor leading the consultation and the patient, and between the two senior doctors), they have the effect of competing with each other. The duration of the consultation is three minutes and eight seconds.

A key explaining how different coloured text is used to represent the different consultation phases and show how they interlock through the course of the consultation. Different activities that occur through the consultation are labelled in colours corresponding to the phase in which they appear.

**KEY**

The consultation transcript (below) has been colour-coded for consultation phase. Orange represents the opening, blue represents the consultation core, and purple represents closing. Participant coding is as follows:

- **D** = lead doctor (junior doctor/registrar),
- **P** = patient,
- **S** = student,
- **D1** = second doctor (senior doctor/consultant);
- **D2** = 3rd doctor (senior doctor/consultant).

Note that doctors are coded to show their role in the consultation rather than their rank. ‘D’ notates the lead doctor for that consultation; ‘D1’ and ‘D2’ denote subsidiary doctors for that consultation. In C48, the lead doctor is junior (a registrar), while the two subsidiary doctors are both senior consultants.

The transcript of Consultation 48 (C48) shown below is broken into sections in order to illustrate the phases of the consultation and the activities that occur within
them. These activities are discussed in more detail in the following chapters with reference to examples taken from the data set as a whole.

A colour-coding scheme is used in this transcript to show how consultation phases fit together. This is done to optimize readability, and to convey a clearer sense of the internal structural ‘shape’ of the consultation.

4.4.3.2 Opening

Extract 1 The consultation opening (C48)

```
OPENING

Becoming co-present/entry
1  ((Medical team arrives))

Greetings and confirming patient identity
2  D  Morning Melissa= ({P lying facing entry to consultation space})
3  P  Haillo:

Settling in
4  (0.1) ({medical team enters space})

Howareous/pleasantries
5  D  How are you this morning ({P starts to roll to face towards D})

Settling in & howareous/pleasantries
6  B  Brian just grab the curtain.
7  (0.1) ({Brian, junior doctor, pulls curtain around bed})
8  P  Good=
9  S  Haillo:
```

The opening phase at the beginning of C48 is brief. Its duration is just under six seconds, but it had a structural complexity characteristic of the openings of bedside consultations in this study. Within the initial opening section, the participants completed five activities, namely: becoming co-present, greetings, confirming the patient’s identity, settling in, and howareous/pleasantries. Later in the consultation, between lines 62 and 72, the opening is reinstated for a further five seconds when a second senior doctor arrives during the course of the consultation core. At this point, the activities of greetings and the additional activity of introductions
take place before the doctor leading the consultation resumes the activities that this later arrival interrupts.

The opening phase at the beginning of C48 begins with the arrival of the medical team into the consultation space by the patient’s bedside in what can be described as the activity of becoming co-present. As they arrive, the patient lies in bed facing the door into the ward, thereby using embodied means, specifically her body and gaze, to orient to the team’s arrival and the consequent beginning of the consultation.

At beginning of the consultation, the doctor who leads the consultation arrives in the consultation space just before the rest of the team and greets the patient by name, thereby initiating the activities of greeting and confirming the patient’s identity. The patient completes the greeting sequence while still lying in bed facing the entrance to the ward as the team arrives. Immediately after the greeting sequence, the doctor initiates a howareyou sequence at line four, to which the patient responds, as such, at almost the same time as the junior doctor greets her.

Following the team’s arrival, the leading doctor initiates the activity of settling in through a request sequence addressed to the junior doctor, who provides an embodied response at line six. The action through which the junior doctor accomplishes the settling in is to pull the curtain around the patient’s bed to prepare the space for the consultation by providing the patient with a nominal degree of privacy. This settling in activity is inserted within the howareyou activity (Schegloff, 2007), bracketed between the first and second parts of the howareyou sequence addressed to the patient at lines four, to which she responds at line seven.

During the course of the consultation opening, the participants orient to the overall structural organization of the consultation as a whole. On arrival, the leading doctor moves to the window (far) side of the bed to the position from which he leads the consultation from that point on. Initially the patient maintains the orientation of her body and gaze direction towards the entrance to the ward but as the opening activities are completed, she gradually prepares to shift these in a stepwise
fashion, first rolling onto her back and looking up and finally rotating her body and
gaze direction towards the doctor.

As the patient gradually shifts her body orientation, the doctor moves to pick up
the patient records, opens them and steps towards the bed, and in a demonstration of
their jointly coordinated orientation to the progression of the consultation to the next
phase within the context of a wider organizational structure, the patient completes her
shift in body and gaze orientation towards the doctor and mutual gaze between them is
established at the moment when the doctor completes his opening of the core business
of the consultation at line nine.

4.4.3.3 Consultation core

The consultation core in C48 contains twelve different activities, some which are
repeated at different points (e.g. verbal examination, providing feedback), and some
which are ‘displaced’ from other phases (e.g. greetings, introductions, case
presentation). All the activities are initiated by the leading doctor but subsequently co-
constructed by participants. The duration of this section of the consultation is three
minutes and 40 seconds. As mentioned in §4.3.3.2, the brevity of this complex central
section of the consultation belies the amount of clinical and interactional work
achieved within it.

The activities in the consultation core in C48 are: opening business, gathering
information through verbal examination, providing feedback, physical examination,
greetings, introductions, treatment proposal, discharge discussion, PFR and making
arrangements for post-discharge follow-up care, case presentation and addressing final
questions. Although there is a degree of messiness in the ordering of the activities
conducted during the consultation core, participants appear to orient to a larger
organizational structure that guides their conduct and responses (e.g. Extract 2
below).

Extract 2  Addressing final questions (C48)

199  P  How long d'you think that I'll take to get
200  D  (.)
201  D2  [Which antibiotics? ]
The asymmetrical distribution of agenda-setting authority is a dominant feature of the bedside consultation, with relatively little opportunity for patient-initiated actions or activities, and few overt invitations to participate in collaborative activities. The only exception (see Extract 2 above) is the joking invitation by the (junior) doctor at the end of the question sequence initiated by the patient about the details of the discharge arrangements (line 221: D “let’s not be too optimistic”). This joking proposal projects the administrative process of discharge as an activity that is disjunctive with that which is currently underway (Stivers & Sidnell, 2010). It casts doctor and patient as a collaborative team facing an unpredictable hospital timetable within a larger institutional organization beyond their control.

Extract 3  Information gathering (verbal and embodied examination) & feedback (C48)
Providing feedback

D: Ok:ay ((looking at notes))
P: (.)
D: Your numbers are good ((reading notes))
P: (.)
D: You haven't had any fevers ((reading notes))
P: (.)
P: No
D: Very good

Gathering information: Physical examination/feedback

D: Neow ((putting notes on table))le:ts
D: (.)
D & P look at leg, P starts to remove sheet covering leg)
D: (0.5) (D walks to bed and helps P uncover leg)
D: okay ((Looks at leg))
P: It feels better today than it has been ((looks at D))
D: its certainly no [worse ]((turns to look at P = 'worse', MG))
P: [Yeh no ] ((MG = 'no', shakes head ))
D: <I'm just going 'n compare it> to the other side ((D & P look at the leg))
D: (0.3) (examines other leg; D looks at leg, P looks away)) what about the
D: pain?
D: yeah? ((D looks at leg, P looks away, smiles at other D with D's 'yeah'))
P: .(0.2) (P looks away)
D: Both sides are equally warm there ((D looks at leg, P looks at D with
D: 'both sides'))
D: .(0.2) (D continues to examine leg, D & P look at leg))
D: and
D: (.) (looks at P) (external noise)
P: Thats not too bad((eyebrows up, head nod, MG))
D: Oh! You're actually able ter
D: (.) (looks at P, smiles))
P: Touch it (MG, repeated head nods and smile)
D: Yeah! Yeah tha tha
P: (.)
P: That's ((A senior doctor arrives))
D2: Its the same one

The doctor collects information about the patient’s current condition and symptoms through verbal then physical examination (Extract 3 above). Each of these activities comprises two linked and sequential parts: information collection followed by feedback provision, with the doctor initiating actions and activity and the patient playing a more passive, receptive role. However, in the verbal examination, feedback follows the entire examination, whereas during the physical examination, feedback is provided throughout the process in the form of ‘online commentary’ (Heritage & Stivers, 1999, Heritage, 2017).
The doctor conducts the verbal examination using a series of abbreviated questions (lines 14 to 33), optimized for ‘no problem’ responses (Boyd & Heritage, 2006), checklist style, before giving feedback (lines 27 to 35). The physical examination is conducted in a broadly similar fashion (i.e. question sequences followed by feedback provision), however using a different organizational structure where online commentary is used to manage the patient’s understanding of what is about to be done and what the doctor is noticing during the examination process. This difference in the organization of different forms of information collection may orient to the difference in sensitivity between verbal examination and physical touch. Online commentary in this situation appears to be chiefly for the benefit of the patient rather than to facilitate efficient teamwork, as it is reported as being used to do in the Emergency Department (Heritage, 2017).

Treatment proposals, discharge discussion and arrangement-making are all organized in a similar way. The doctor gives a directive (“give us a call”) or informing statement (“I think we can let you go home now”, “We’ll need to see you back in the clinic”, “we’ll give you enough Keflex t’last ... at least eight days”), before eliciting the patient’s embodied agreement or understanding, chiefly through gaze and nodding. Again, the doctor initiates new activities and actions, and the patient’s role is limited to confirming her understanding of and/or agreement to proposed courses of action.

After the arrival of the additional senior doctor (line 60), examination, treatment and discharge proposals and discussion become more interactionally complicated. After the second senior doctor’s arrival, the role of leading doctor shifts between the junior doctor who has until now been leading the consultation, and the newly arrived senior doctor. Shifts in gaze direction and body orientation by participants are important resources for maintaining continuity through this process for all participants. For example, the (junior) doctor leading the consultation orients his body towards the patient, with whom he maintains mutual gaze during his information gathering activities early in the consultation. As the consultation progresses, he shifts his body orientation and gaze towards the senior doctors standing at the end of the patient’s bed.
while he discusses possible follow-up appointment timing with them. Similarly, the patient (who lies in bed throughout the consultation) directs her gaze towards the junior doctor while information gathering activities are underway but shifts her gaze direction towards the senior doctors when she discusses possible times for follow-up appointments.

Throughout the consultation, the other junior members of the medical team are essentially passive observers, in keeping with their role as trainees observing the conduct of a consultation by more experienced clinicians. These observing participants in turn orient their bodies towards the patient as the core activities of the consultation are conducted. Their gaze direction follows the direction of the main ‘action’, focusing mainly on the recipients of questions as the consultation progresses. This means that their gaze shifts from patient to senior doctors as the activities are undertaken.

Transitions between activities are often accomplished by sequence closing assessments such as “good”, “very good”, “fantastic”, “excellent”, “sounds great”, “that’s fine”, often followed by the change-of-state discourse marker “okay”, which projects both backwards, registering the completeness of the activity it sits at the end of as well as projecting forward to a next activity. ‘Okay’ used in this situation marks a disjunction between interactional units (such as activities) that are not directly emergent or related to that just finished and which precedes a sequence initiating action (Bolden, 2014; Gardner, 2001; Beach, 1993).

**Extract 4 Offline case presentation and addressing final concerns/questions (C48)**

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
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</thead>
<tbody>
<tr>
<td>194</td>
<td>D1</td>
<td>She had a really nasty cellulitis</td>
</tr>
<tr>
<td>195</td>
<td>D</td>
<td>(.)</td>
</tr>
<tr>
<td>196</td>
<td>D</td>
<td>see the original markers</td>
</tr>
<tr>
<td>197</td>
<td>D2</td>
<td>Yeah</td>
</tr>
<tr>
<td>198</td>
<td>D</td>
<td>Okay?</td>
</tr>
<tr>
<td>199</td>
<td>P</td>
<td>How long d’you think that I’ll take to get</td>
</tr>
<tr>
<td>200</td>
<td>D</td>
<td>(.)</td>
</tr>
<tr>
<td>201</td>
<td>D2</td>
<td>[Which antibiotics? ]</td>
</tr>
<tr>
<td>202</td>
<td>P</td>
<td>[Everything done before] I can go? (looks at D, D returns to the space, looks at P)</td>
</tr>
<tr>
<td>203</td>
<td>D</td>
<td>[Oh not long ]</td>
</tr>
<tr>
<td>205</td>
<td>(.)</td>
<td></td>
</tr>
</tbody>
</table>
The patient is given no explicit opportunity to raise concerns or ask final questions (see above extract). That is, the doctor does not elicit final concerns from the patient (e.g. by asking a question such as ‘do you have any questions [before we go]?’).

Consequently, towards the end of the consultation core, after the doctor has finished making pre-closing arrangements and is making a transition to closing the consultation by beginning to walk out of the consultation space (Broth & Mondada, 2013), the patient initiates a brief sequence of information seeking questions (line 188 to 216). These questions are conducted against a ‘backstage’ case presenting conversation between the two senior doctors, one who arrived midway through the consultation and one who was present at the time of the late arrival. The pre-present senior doctor gives an abbreviated summary of the patient’s situation, in what serves as an informal case presentation between peers. The situation where parallel conversations are being conducted, exemplifies the often noisy and confusing environment where many bedside consultations occur. It also displays a professional norm where it is acceptable for senior practitioners not to attend to the actions of juniors (although this is probably not a reciprocal right).
The ‘offline’ case presentation between the two senior doctors is conducted between lines 85 and 108 (refer Appendix 6). At this point in C48 (and in other consultations in the study data), and when attempts are made at pre-emptively initiating other activities, these actions are responded to as if in the service and context of the larger project of the consultation.

Extract 5  Orienting to ‘Misplaced’ Activities (C48)

55  D  Oh! You're actually able ter
56  .)((looks at P, smiles))
57  P  Touch it ((MG, repeated head nods and smile))
58  D  Yeah! Yeah tha tha
59  .)
60  D  That's ((A senior doctor arrives))
61  D2 Its the same one

Greetings

((another senior doctor arrives))

62  D1  Hi Melissa ((D stops examination and stands up))
63  P  Hello ((looks at D1, eyebrow flash and smiles))

Participants orient to such episodes of reversion to activities ‘belonging’ to an earlier phase of the consultation as interruptive to the overall progression through a larger organizational structure framing the ‘project’ and support the return to that progression. In Extract 5 (above) this orientation is displayed using both verbal and embodied actions as the leading doctor abruptly aborts his utterance mid-turn (line 60), halts the physical examination that is underway, stands up and turns towards the arriving senior doctors (line 62). After the junior doctor stops mid turn (line 60), the arriving doctor completes the utterance (line 61). After completion of the opening activities of greetings and introductions (which the leading doctor conducts at lines 64-70), the leading doctor turns back to the patient after a brief pause and resumes his examination (line 73).

On completion of the opening activities, the leading doctor redirects the interaction to the core activities that had been interrupted by the late arrival, thereby orienting to a pre-established agenda of tasks needing to be accomplished in the consultation. The other participants acquiesce to this reinstatement of the prior activities (albeit through a stepwise transition marked by change of state and sequence ending discourse markers),
thereby also orienting to a larger structural framework for the consultation that had been interrupted and should relevantly be returned to. After the patient has been introduced to the newly arrived senior doctor (lines 64 to 68a) and acknowledges the introduction (line 69), the doctor shifts the focus of the consultation, in a stepwise fashion, back towards the physical examination that had been underway before the arrival of the senior doctor (lines 71 to 80 in Extract 6 below).

**Extract 6  Focus redirection between activities (C48)**

64  D  You
65  
66  you’ve met
67  
68  Dr Roberts before=(puts hands together in front of body in cupped gesture) before=
68a  
70  P  Yes::
71  
72  
73  (0.2) (smiles, looks at D2)
74  
75  D  Okay
76  
77  so:: ((turns toward P, hands still held together in front of body))
78  
79  (.) ((P looks at D))
80  
81  ehm ((D extends index finger to point at leg from two hand gesture))
82  
83  (0.1) ((P looks at D))
84  
85  it’s certainly looking no worse
86  
87  (.) ((D frowns through MG))
88  
89  ehm the tenderness ((D forms two-handed open hand offering gesture)) is
90  
91  almost completely resolved

Similarly, attempted initiation of activities before normatively prior activities have been completed, are treated as interruptive and implicitly sanctioned by being ignored and are only jointly conducted once these prior activities have been completed. An example of this situation in C48 is when the patient tries to initiate discussion about her discharge near the beginning of the consultation (line 11, see below) and before the normatively preliminary activities have been completed. Discussion of discharge timing and arrangements are finally embarked upon much later, after completion of the normatively prior activities of information gathering and examination, at line 113.

There is evidence of participants orienting to a normative overall structural organization for the consultation at the beginning of the consultation core, when the
patient fails to return the floor to the doctor at line ten after responding to his sequence-initiating opening elicitor (see Extract 7 below).

**Extract 7  Unsanctioned focus change  (C48)**

9  D  You feeling well?=
10  P  Yes, ((turns to look at D; MG synchronized with ‘well’))
11  D  [I need] to go home ((smile))
12  D  [Good ]
13  .

In doing this, her action is treated by the doctor as contravening norms regarding the distribution of rights to set agendas during the consultation as well as regarding the order in which activities should occur.

The patient treats her attempt to set the consultation agenda at this point and skip to discussion about discharge as transgressive by establishing mutual gaze with the doctor and smiling as she makes her request/statement. The doctor treats the patient’s action as unsanctioned by failing to produce a relevant second part acknowledgment to it (i.e. an acceptance or refusal of the patient’s request). He produces a sequence-closing assessment (“good”) arguably hearable as referring to the patient’s prior response in line 10 (“yes”) to the opening elicitor in line 9. In doing so, the doctor is asserting his right to set the consultation agenda. The doctor’s assessment at this point thereby returns the consultation trajectory to his preferred agenda by refusing to take up the proposed change of direction embedded in the patient’s request, which is treated as an attempt to initiate an activity prematurely, as well as by a participant unauthorized to do so. Both participants therefore treat the opening elicitor as a relevant and timely means of launching the first activity of the consultation core, and to the doctor as the participant entitled to set the agenda at this point.

In reasserting his preferred agenda (as well as his right to reassert it) the doctor orients to the normative organizational structure of the consultation whereby the activity of discussing the patient’s discharge arrangements and timing only become
relevant after the doctor has completed such other activities as assessment of the patient’s condition, the current diagnosis, and treatment plans. The patient’s attempt to introduce the activity of discharge discussion is therefore also treated as an attempt to subvert the normative sequence and therefore structure of the consultation. The action can therefore be seen as dispreferred both because of where it occurs in the order of activities, and because of it having been launched by the patient rather than the doctor.

Both doctor and patient treat the patient’s attempt to assume an agenda-setting role in this example as problematic, suggesting that they are orienting to a norm that the doctor not the patient has the right to set the consultation agenda. As well as contravening the norms concerning distribution of rights to set the consultation agenda, the patient’s proposed topic shift to discharge discussion discussed above also contravenes those of the overall structural organization of the consultation, which dictates that discussion about patient discharge from hospital (only) occurs after a verbal and usually physical examination (as well as other activities). The patient’s action in C48, where she smiles and establishes mutual gaze with the doctor as she produces an implied directive in line 11 (“I need to go home”) is not otherwise readable as a laughable or an utterance normally accompanied by a smile, and the doctor’s response to her action described above (ignoring the patient’s request initially and delaying response to it) shows that both participants orient to this overall structural organization.

**Extract 8  Reasserting ‘normative’ agenda – initiating discharge discussion (C48)**

113  D  [Okay !(.) ]I think we can let you go home ((looks at P, smiles broadly))
114  P  Oh {may}  ((P looks at D, blinks smiles broadly))
115  D  [Huh huh] huh huh
116  P  .{returns to look at D1})
117  D  okay
118  P  .{returns to look at P})

Further evidence of this orientation to the overall structural organization as normative is that discharge discussion is finally initiated (by the doctor) at the point in the consultation (Extract 8), when the other activities have been completed in the normative order. When this happens, the doctor smiles as he announces (line 113): “I
think we can let you go home”. The fact that both doctor and patient smile when the doctor makes this announcement, one that would not normally elicit a smile, is evidence that both the doctor and the patient orient to it as a delayed response to the patient’s contribution in line 11. The patient smiles broadly in return, and both doctor and patient laugh following the patient’s subsequent acknowledgment of the doctor’s proposal.

It can be argued that in initiating the activity of discharge discussion albeit at the normatively correct point in the consultation, in this case the doctor is also providing a (very) delayed response to the patient’s earlier request to go home. If so, this is further evidence of the doctor enforcing norms regarding the distribution of rights to agenda setting in the consultation. However, it also suggests that the doctor has found a way to simultaneously display his acknowledgment of the patient’s agenda and concerns within the constraints of the institutional norms and professional practices into which he is being socialized. The doctor and patient’s shared smiling and laughing that follows the announcement suggests that both orient to this additional dimension of the doctor’s officially sanctioned authority and action. To be fair, it is also possible that the doctor might just only now have gathered the information needed earlier but lacked to grant the patient’s earlier implicit request to be discharged.

Overlap occurs across speech and non-word vocalizations such as laughter in C48. Overlapping talk typically marks moments of awkwardness and/or associated problems in co-ordination (see Extract 9 below). As noted at one point in the consultation, simultaneous but separate conversations occur within the consultation space between different sets of medical team members (lines 188 to 215), and at other points, overlapping talk occurs where there was some kind of interactional trouble. For example, when the patient makes her previously discussed attempt to take control of the consultation agenda at line 11, the doctor’s sequence closing assessment (‘good’) that reinstates his earlier opening elicitation (‘Are you feeling well?’) overlaps the patient’s assertion that she needs to go home. The doctor’s overlapping talk thereby marks his utterance as not only a sequence closing assessment, but also (in its placement in overlap with the patient’s unauthorized bid for the agenda) possibly as an interactional sanction.
Overlapping talk at this point in C48 maps the continuing relevance to participants of the patient’s norm-violating action (Extract 9 above), when towards the end of the doctor’s verbal examination of the patient, at line 24 she precedes her embodied negative response to the doctor’s final (indistinct) question with a joke “I wouldn’t tell you anyway” that overlaps the doctor’s question. The joke is accompanied by a smile and overlapping laughter by both doctor and patient follow.

Laughter has been shown to be a resource drawn upon to manage awkward moments in the medical (and other) interaction (Haakana, 2001). In C48 the shared (therefore overlapping) laughter between doctor and patient at this point is treated as marking the patient’s norm violation. This shared laughter also signals both participants’ orientation not only to the patient’s original violation but also to her subsequent signal, through the joke, that she still wishes to pursue the ‘unauthorized’ agenda the violation advocates.

In other words, the patient’s joke at line 24 acts to repeat her challenge to the norm concerning the distribution of agenda setting rights in the consultation by announcing a lack of co-operation with the activity of verbal examination in service of her wish to go home. The fact that the doctor shares in the laughter that follows the patient’s joke oriented to the patient’s continuing effort to redirect attention to her agenda, also has the effect of being sequence closing, as shared laughter towards the end of an activity has been shown to often be (Holt, 2010), particularly as it is followed by a
short pause and then a more strongly sequence closing ‘okay’ from the doctor at line 27.

Other instances of overlapping speech in C48 occur at points of interactional uncertainty, such as at lines 88 to 90, where the role of consultation leader is being transferred between the senior and junior doctors at the conclusion of the verbal and physical examination of the patient and prior to initiation of the activity of discharge discussion. After the arrival of the senior doctors (discussed above), the activity of physical examination is resumed, overlaid by an abbreviated case presentation, before further verbal examination of the patient occurs. These examinations are jointly conducted by one of the senior doctors and the junior doctor. In ceding leadership of the consultation back to the junior doctor, the senior doctor orients to the junior doctor’s prior claim to the position of leading doctor for this consultation, possibly partly for the purposes of supervision as well as respect. The overlap at line 88 seems to mark a problem in coordination between the doctors, as the junior continues the sequence of sequence-closing assessments by both he and the senior (‘yeah’(.) ‘fantastic’(.) ‘sounds great’) with the sequence and activity-closing ‘okay’ (line 118).

Overlapping speech can also signal a transgression of role-related normative behaviour, for example, following an uninvited assessment by the patient of the progress of her infected leg early in the physical examination, at line 41, ‘it feels better today than it has been’, the doctor produces a downgraded version of the patient’s assessment (line 42) ‘it’s certainly no [worse]’. The doctor’s response to the patient’s remark is framed objectively (‘it’s certainly no worse’), marking the patient’s subjectively framed contribution (‘it feels better’) as dispreferred. The patient’s face-saving (Burridge & Florey, 2002) response of ‘[yeh no]’ (line 43) that overlaps the end of the doctor’s turn treats this as a potentially face-threatening sanction (for transgressing the asymmetrical distribution between participant roles of rights to make un-elicited assessments), marking an awkward moment in the consultation.
It is important to note that next turns are not always *spoken* but are sometimes delivered in an embodied medium. This is particularly evident during the verbal examination (Extract 9 above), which is conducted by the doctor in an abbreviated ‘checklist’ fashion, with the selected next ‘speaker’ (the patient in this case) providing a relevant embodied response, such as a head-shake (to indicate ‘no’). This example raises the possibility that embodied responses to ‘checklist’ questions pass as an equivalently ‘checklist’ response, and that in responding in this way, the patient is orienting to the doctor’s interactional agenda as well as his organizational and clinical agendas.

4.4.3.4 Closing

In this consultation, the doctor does not elicit final questions or concerns from the patient during the closing, but instead, the patient takes control of the agenda during the latter part of the consultation core to ask, uninvited, several questions to clarify her understanding of discharge arrangements. The sequence where the leading (junior) doctor addresses the patient’s final questions overlap with an informal ‘backstage’ case presentation by one of the senior doctors to the other. This simultaneous exchange exemplifies the complicated, busy, sometimes confusing and noisy character of the bedside consultation.

The closing section in C48 is brief. Participants treat the closing as being that section between lines 233 and 247 (refer Appendix 6) where the senior doctor (who is supervising the junior doctor who leads the consultation overall) briefly reiterates pre- and post-discharge arrangements to the patient, accomplishing the activity of ‘making final arrangements’ as part of the closing phase. The shift-implicative ‘so’ also marks a transition to closing – so in that sense the reiteration of discharge arrangements functions as a pre-closing sequence, similar to that often seen in primary care consultations. At this point, the doctors break co-presence by walking away, leaving the consultation space, looking back and waving and smiling as they do so. Walking away has been shown to be an embodied resource used to project the closing of an activity or of the larger activity of an entire episode of interaction (Broth & Mondada, 2013). In C48, the doctors’ deployment of a range of embodied resources to achieve the severing of the link established during the consultation demonstrate the complex
nature of the achievement of closing an interaction in general and in this setting in particular (Schegloff & Sacks, 1973).

The patient then thanks the doctors who then initiate an informally-worded farewell sequence (D1: “see ya”) in line 246, from their location part way out of the interaction space. In leaving the space before completing the farewell sequence, the doctors treat this activity as partly dispensable, a formality, possibly almost superfluous. In response to the doctor’s first part farewell, the patient does not provide a fitted second part farewell, but rather a sequence-closing assessment (P: “excellent”). This disjointed final section illustrates some awkwardness and difficulty in achieving the final disengagement. This is evident in the doctor’s subsequent farewell first pair part “see ya” being overlapped by the patient’s unmatched second part “excellent” at line 247, which is the final utterance of the consultation.

4.5 Conclusion

In this chapter, the overall structural organization of the bedside consultation is described with reference to the bedside consultation as a whole, to the key phases of the bedside consultation, and to the place of the bedside consultation in the ward round visit.

General contextual features of the consultation are also presented, to provide a broad overview of the consultation. Different types of ward round conducted in the hospital in this study are discussed as are participants in the consultations, types of bedside consultation, consultation duration and the distribution of turns at talk between participants.

In addressing the first research question, this chapter has established that there is a clear overall structural organization in the bedside consultation. Using C48 as a reference point, it appears that participants in the bedside consultation orient to a particular overall structural organization for the bedside consultation. This is suggested in their conduct and in their shaping of the encounter interactionally at different levels.
At the level of the bedside consultation, participants orient to the following normative overall organizational structure for the consultation: an opening, a core section during which activities directly related to the medical clinical work of the consultation are conducted, and a closing. The opening and closing sections can be thought of as (composite) activities in their own right, with their own internal structures, as well as phases in the overall consultation structure.

At the level of activities within these three main phases, participants appear to orient to the following. The opening is constructed from the following activities: becoming co-present, greetings, identity checking, settling in/registering, howareyou and (both inserted in the consultation core) introductions and case presentation. The consultation core is made up of the following activities: opening business, verbal examination, physical examination, providing feedback, treatment discussion, PFR, discharge discussion, discussing next steps/care plan. The closing comprises: summarizing/finalizing arrangements, addressing final questions (inserted in core). thank-you, arranging next steps (post-discharge follow-up), farewells, breaking co-presence.

Although particular activities normatively ‘belong’ in specific consultation phases and occur in a normative sequence and order, there is some flexibility in this. An activity can occur in a ‘wrong’ phase of the consultation (e.g. opening activities in the consultation core), in addition to or instead of occurring in the normatively correct position. Despite the degree of flexibility evident in placement and ordering of activities in the consultation, participants treat some variations as being more or less problematic than others. For example, the repetition or reinstatement of an activity that has already been completed earlier is treated as being more acceptable than an activity attempted ‘prematurely’ in relation to the normative organizational structure.

The next chapter focuses on the opening of the bedside consultation and examines its internal organizational structures and interactional practices through the activities that participants co-construct. The discussion is illustrated with examples of activities and interactional practices from the study data.
The multi-layered nature of the consultation is highlighted by the fact that the consultation opening can be viewed as an activity in itself, and also as a larger interactional unit containing subsidiary activities and actions. These subsidiary activities were outlined in this chapter and are explored in more detail in Chapter 5.
Chapter 5  How the bedside consultation is opened

5.1  Introduction

This thesis describes how the bedside consultation is done and considers whether there are differences in the way it is organized and conducted compared with how consultations in other clinical settings are done, and if so, how such differences may be accounted for.

This chapter and the following two results chapters (Chapters 6 and 7) develop observations made in Chapter 4 about characteristic organizational features of the bedside consultation, with reference to the entire body of study data. In this chapter, the focus is the consultation opening, and on the question of how participants work to achieve the alignment of focus necessary to conduct the work of the consultation.

(An) opening is the solution to the problem of “how participants begin occasions of talk-in-interaction” (Sidnell, 2010:197). Although this sounds obvious, the establishment of coordinated focus of attention and negotiation of joint purpose by a group of individuals is a complex interactional achievement. In this chapter, the second research question, which frames this issue with relation to the bedside consultation, is addressed. It is:

RQ2:  How is the bedside consultation opened?

This chapter begins with the presentation of some simple quantitative findings about the consultation opening, with discussion of the duration of the consultation opening (§5.2.1) and of distribution of the exercise of agency between participants, in terms of initiation of new activities (§5.2.2).

The overall organizational structure of the consultation opening described in Chapter 4 incorporates seven activities that are discussed in this chapter with reference to the entire data set for this study. These activities are: entry/becoming co-present (§5.3.1), greetings (§5.3.2), confirming patient identity (§5.3.3), settling in/registering (§5.3.4), introductions (§5.3.5), howareyous/pleasantries (§5.3.6) and case presentations
During analyses through the thesis, reference to other, unanalyzed, instances of the phenomenon under discussion in the data may be made thus: (C16, C4).

It was noted in the previous chapter that the organization of the bedside consultation is variable to some degree in its content and in the placement of activities within different consultation phases. To reiterate, some activities do not occur in some consultations, some occur more than once, and some occur ‘out of order’. This variability and iterative character have been widely noted in the literature with reference to medical consultations in a range of settings. Notwithstanding, the activities included in this chapter (and also in later chapters) are discussed at the point in the consultation where participants treat them as being normative.

In addressing the problem of how to begin conversation, participants signal their mutual preparedness and availability to begin an extended conversation, after establishing that they are possible co-conversationalists (Sidnell, 2010). They then constitute or re-constitute a relevant interactional relationship, and establish what will be talked about (Schegloff, 1986). Participants in medical consultations commonly begin their encounters orienting to a social relationship or what Coupland et al (1994) refer to as a ‘relational frame’, and during the course of the opening, they shift the character of their relationship to a medical, professional, institutional ‘frame’ (Goffman, 1974). This is an important component of the work of the opening as it involves establishing the roles, with associated interactional rights and responsibilities that participants play for the occasion. These roles establish who participants ‘are’ to each other for that occasion (Rossano, 2012), and they consequently play a pivotal part in shaping the conduct of the consultation.

Pillet-Shore (2008) gives a detailed description and analysis of the process through which people pass during the opening of a conversation, using data from ‘mundane’ social settings as well as from educational settings. She emphasizes the centrality of achieving alignment in availability and readiness, focus of attention and tacitly agreed roles for the encounter. It turns out that, based on this study data, many of these observations hold true for the opening of the bedside consultation as well. During the primary or secondary healthcare consultation the process of participants shifting into
their roles for the consultation is typically achieved through a series of activities including: summons/approach, entry of the patient into the room, a greeting exchange (usually initiated by the doctor), ‘dispositional talk’ or the offering of ‘hospitality’ (typically by the doctor offering the patient a seat), a ‘familiarity sequence’ or set of introductions, the reading of patient records by the doctor, a ‘howareyou’ sequence (also typically initiated by the doctor), and additional optional sequences such as welcomings (often incorporated into greetings by the doctor), apologies (for example regarding late arrival), and/or compliments (for example regarding personal appearance or other non-medical attributes).

Describing the organization of the primary healthcare (first) visit, Robinson (2014:261) distills this process into a set of four canonical activities of the consultation opening as being: (1) greeting, (2) securing patient’s identity, (3) “retrieving and reviewing patients’ records” and (4) “embodying readiness (e.g. sitting down and facing on another”). In the following sections, the way this opening work is organized and conducted at the bedside is described.

5.2 Features of the consultation opening

5.2.1 Opening duration

The opening of the bedside consultation is brief, taking an average (mean) 13 seconds or 4% of the total duration of the consultation. Findings about the duration of the bedside consultation as a whole in this study are more or less aligned with results reported in the small (but growing) literature concerned with interaction in hospital ward rounds.

Openings of interactions in general conversation have similarly been shown to be short, but the literature shows that much work is done during this part of an interaction (Schegloff, 1968, Robinson, 1998, Pillet-Shore, 2008). It turns out that the same can be said of the opening of the bedside consultation (as well as other kinds of medical consultation).
When the duration of the opening is considered, particularly in relation to that of the overall consultation, the interactional power of this part of the encounter is evident. In other words, despite being brief, a lot of important interactional work happens during the consultation opening. Crucial connection and alignment are made between participants, and they coordinate their focus of attention and negotiate and signal commitment to co-operate during the consultation. The initial seconds or minutes of a medical consultation are consequently an important component of the encounter, as has been recognized in much prior literature regarding medical and mundane interaction, and a valuable source of information about the initial orientations of participants.

5.3 Overall structural organization of the consultation opening

In this chapter, I refer to insights into how openings are achieved both in medical interaction (Byrne & Long, 1976; ten Have, 1989; Heath, 1981; Coupland, Robinson & Coupland, 1994; Robinson, 1998; Heritage & Clayman, 2010; Paul, 2015) and in general conversation (Schegloff, 1968; Pillet-Shore, 2008) and drawing on both perspectives to describe how openings in bedside consultations are brought about.

This discussion of the consultation opening includes all the actions and activities that occur prior to the commencement of the medical business of the consultation (discussed in Chapter 6). The opening activities and actions discussed here include ‘boundary actions’ (such as greetings and introductions) which are excluded from some research into consultation openings (White, 2011). These actions are included in this study because if activities occur during the consultation opening, then they are relevant to participants and are consequently relevant and necessary for the researcher to observe, document and examine in an attempt to understand what participants use them to achieve and how.

Findings from the extensive literature on consultation and other conversation openings, as discussed in Chapter 2, show that openings play an important role in setting the tone for the rest of the consultation in terms of the level of alignment achieved by participants, and the identities and interactional roles they orient to for the encounter.

The internal structure of the bedside consultation opening is shown below in Figure 11 below. It is variable in the sense that not all possible opening activities occur in all consultations in a similar way that the structure of the overall consultation is variable. Unlike the consultation as a whole, however, activities in the opening are not usually iterative, that is, they are seldom completed then reinstated later on in the opening. That said, opening activities may occur during a later phase of the consultation, as is evident in the consultation (C48) discussed in Chapter 4, when mid-way through the core ‘business’ phase of the consultation two senior doctors arrived at the bedside and the opening activities of greetings and introductions became relevant and occurred at this point. In that case, these opening activities can be seen to be iterative in terms of the consultation as a whole, because the business activities of the consultation core are suspended in order to temporarily reinstate the opening phase through the opening activities of greetings and introductions. In contrast to that consultation level iterative structure, within the opening phase of the consultation, there is little evidence that activities that have been accomplished and completed are later returned to.
Figure 11  Activities in the consultation opening

* The star symbol denotes activities that do not typically occur during other kinds of medical consultation, so are unique to the bedside.

Re-establishing the clinical relationship is a central task (arguably the central task) of the consultation opening. The structure of the opening is distinctive when compared with openings described in other medical contexts, as well as in mundane conversation, and is represented in Table 5-1 below.

Activities unique to this setting or done distinctively in it compared with what is known about how they are done elsewhere are shown in bold text.
Table 5-1  Re-establishing the clinical relationship at the bedside (the overall work of the opening)

<p>| | |</p>
<table>
<thead>
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<tbody>
<tr>
<td>1.</td>
<td><strong>Becoming co-present (distinctive form)</strong></td>
</tr>
<tr>
<td>2.</td>
<td>Greetings (this can be accompanied by touching, e.g. hand-shaking)</td>
</tr>
<tr>
<td>3.</td>
<td><strong>Introductions (characteristic of bedside)</strong></td>
</tr>
<tr>
<td>4.</td>
<td><strong>Doing ‘settling in’ (distinctive form at the bedside compared to other settings)</strong></td>
</tr>
<tr>
<td>5.</td>
<td>Howareyou sequences (much more common in regular than changeover consultations – 70/30)</td>
</tr>
<tr>
<td>6.</td>
<td><strong>Registering (references to some aspect of interaction space, environment or experience e.g. being filmed, being sick, patient being confused)</strong></td>
</tr>
<tr>
<td>7.</td>
<td><strong>Case presentations (unique to the bedside)</strong></td>
</tr>
</tbody>
</table>

This model of the bedside consultation opening in Table 5-1, based on Pillet-Shore’s (2008) model of the opening of general interaction, shows the complex internal organization required to re-establish the clinical relationship. A number of the activities in this organizational model also occur during the opening of a range of other (medical and non-medical) types of interaction, showing how interlinked ordinary and institutional talk are, and that participants in conversation orient to a robust organizing structure to help them manage the challenge of beginning a conversation.

Different contexts of talk are created with reference to an underlying foundational set of communicative practices, and distinctive, context specific activities are embedded into the opening ‘template’. For example, a ‘regular’ medical consultation opening can be described as having the following tasks: co-presence is established, followed by “(a) greeting, (b) getting the patient to sit down, (c) securing the patient’s identity, and (d) determining the patient’s chief complaint (Robinson, 1998).

However, this model shows how participants in the bedside consultation treat aspects of the foundational opening structure as being relevant in ways that are distinctive to this particular medical context. The frequency of activities that characterized the opening of bedside consultations is shown in Table 5-2 below. These activities are: greetings, ‘howareyou’ sequences, introductions, case presentations and laughter talk. Some of these activities can be considered to be generic to consultation openings.
(based on findings in prior research e.g. Byrne & Long, 1976; Robinson, 1998) or to conversation openings in general (Schegloff, 1968; Pillet-Shore, 2008). Other activities appear to be uniquely characteristic of the bedside consultation.

Table 5-2 separates activities into generic opening activities (i.e. those that occur in other types of consultation or in conversation openings in general) from those that are apparently unique to the bedside consultation. Activities that uniquely characterize the opening of the bedside consultation are discussed in detail below (§5.3.1, §5.3.3, §5.3.4, §5.3.6).

**Table 5-2 Activities in bedside consultation openings**

<table>
<thead>
<tr>
<th>Activity</th>
<th>Generic opening activity (% of bedside consultations it occurs in)</th>
<th>Distinctive bedside consultation activity (% bedside consultations in which it occurs)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Entry/becoming co-present</td>
<td>100</td>
<td>N/A</td>
</tr>
<tr>
<td>Greetings</td>
<td>85</td>
<td>N/A</td>
</tr>
<tr>
<td>Doing 'settling in'</td>
<td>N/A</td>
<td>100</td>
</tr>
<tr>
<td>Howareyous/personal state inquiries</td>
<td>44</td>
<td>N/A</td>
</tr>
<tr>
<td>Registering</td>
<td>N/A</td>
<td>51</td>
</tr>
<tr>
<td>Introductions</td>
<td>N/A</td>
<td>29</td>
</tr>
<tr>
<td>Case presentation</td>
<td>N/A</td>
<td>7</td>
</tr>
</tbody>
</table>

Note: Technical problems resulted in a failure to record the opening or the opening seconds of a small number of consultations (n = 3).

Table 5-2 shows that most but not all openings (85%, n = 37) include a greeting sequence. Almost half the bedside consultation openings (44%, n = 19/43) contain personal state or ‘howareyou’ sequences. Neither greeting sequences nor howareyou sequences is unique in form or presence to the bedside consultation compared with consultations in other medical settings (Coupland, Robinson & Coupland, 1994). However, the way they are designed and organized is part of the overall structural organization participants orient to in conducting the bedside consultation, which is in totality, uniquely distinctive.
Introductions and case presentations are unique to and characteristic of the opening of bedside consultations compared with openings of consultations in most other medical settings that have been documented, and they are discussed in more detail below (but introductions occur in genetic counselling consultations, where there are also multiple participants, as described by Paul, 2015). Neither introductions nor case presentations occur in a majority of consultations in this study, but they are both recurrent features of the encounters, and are uniquely characteristic of consultations in this setting. They are discussed in the relevant sections below (§5.3.4 – introductions and §5.3.6 – case presentations).

5.3.1 Becoming co-present/entry

A key activity of the consultation opening is that of participants’ entry to the interaction space or becoming co-present. It may seem self-evident that for a face-to-face encounter to occur all participants must become co-present in the sense of coming into the same physical space, and in an encounter that is physically face-to-face this is true.

However, participants in the bedside consultation (or any interaction) must achieve a sense of social as well as physical co-presence to be able to align the focus of their attention (Pillet-Shore, 2008). This chapter examines how participants at the bedside achieve this intangible kind of co-presence, laying the groundwork for the work they do together.

Technology now makes it possible for participants to be within sight of each other without being co-present in the same physical space, (for example through skype) or alternatively within earshot of each other (for example on different ends of a telephone call) but not in the same physical space. In ‘traditional’ face-to-face interaction where participants occupy the same physical space during the interaction, such as in the bedside consultations in this study, the fact and manner of participants actually coming together are both important facets of the consultation opening. Even at this earliest point of coming together, participant orientations are made available for inspection.
At the bedside, patients await the arrival of the medical team either (most commonly) in their beds, or occasionally, seated in a chair beside the bed. This is true regardless of the kind of room the patients are accommodated in. On many occasions, a computer containing patient records or other relevant notes set on a trolley is also wheeled into the space. The layout of the rooms and furniture is shown in Chapter 4 and Appendix 3. Most patients in this study are in shared four-bed wards, with beds that can be visually screened from neighbouring beds by running a cotton curtain hung from a track above around the bed. In most cases, the curtain is open or mostly open when no consultation or other visit is underway. When the curtain is closed, it defines the interaction space and provides visual and associated psychological privacy for the patient and the others present. Despite the degree of privacy provided by the drawn curtain, speech and other noises from outside the consultation space can be clearly heard through this visual barrier, meaning that speech from within the consultation space is also clearly audible to those outside it. This situation creates a degree of exposure and vulnerability for participants, particularly for patients, whose privacy and associated dignity is compromised by the physical constraints of shared accommodation in multi-bed wards.

In private rooms, patients’ beds are generally located in the middle of the room, well away from the door through which the medical team arrives. After their arrival, medical team members do not usually close the doors of private rooms in the way that they close the curtains around beds in shared wards. However, this does not compromise their patients’ privacy, as the private wards are well away from public areas, and the patient cannot be seen from outside the room nor conversations be heard. In two-bed wards, similar privacy issues apply as are relevant in larger shared wards.

Both doctors and patient orient to the encounter having begun when the medical team enters the consultation space. Although mutual gaze is not always immediately established, both parties almost invariably look towards each other as the doctors approach the interaction space. The doctor leading the consultation usually looks directly towards the patient while other members of the medical team typically look either towards the patient or somewhere inside the interaction space, as they
enter. Patients also usually look at the doctor/s as they arrive and often smile at them as well, as do doctors. Doctors usually look at the patient as they arrive in the consultation space, and quite often they also smile. The same is true for patients. This pattern of participants looking and smiling at each other at the start of an encounter as they come together is also reported in the general literature concerning interaction openings (Pillet-Shore, 2008).

The patient usually turns to look at the medical team as they arrive in the consultation space when s/he can hear their voices or sense their approach. Patients seldom signal that they are anticipating the doctors' arrival by gazing towards the door of the space until they can see or hear the team approaching the space. This may be evidence of the relative unpredictability of components of the hospital routine for patients (or in general). That is, although a bedside consultation occurs daily, its exact timing cannot be precisely predicted. On that basis at least, the bedside consultation is not expected by the patient to occur at any particular time.

Organizational asymmetry between doctor and patient is evident even at this early point in the consultation in the fact that the patient has no control over the timing of the consultation and is therefore obliged to await the doctors’ arrival. The patient is subject to the institutional routine whereby the exact arrival time of the doctors is variable and not known in advance. This imbalance is oriented to by patient comments such as: (Extract 11, (C5): P “we’ve been waiting(.)with bated breath for you!”), and (Extract 10, (C15): P “op (.).there ‘e is!”).

Doctors (and patients) sometimes orient to their lack of full control of the timing of their arrival and to being similarly at the mercy of the institutional routine of the hospital and the somewhat unpredictable nature of their work in it in their responses such as, following on from the excerpt below (Extract 10):

**Extract 10  Becoming co-present: doctors accounting for late arrival (C15)**

```
1   P   Op
2     (.)
3 there ‘e is
```
In this example, the doctors arrive in the patient’s room early in the afternoon, which is unusually late for a type of consultation that usually occurs during the morning. Both doctor and patient orient to the lateness of the doctors’ arrival, an issue that turns out to dominate the consultation opening and be treated as a delicate issue. Indeed, later in the consultation the doctor returns to this topic, marking the issue of adherence to normative roles and routines as important, and deviation from these norms as delicate issues. In effect this shows that participants – both doctors and patients – recognize and orient to a normative organizational structure for the consultation not only in terms of the sequence of activities within the consultation (as discussed in Chapter 4), but also in terms of timing of events within the larger structure of the hospital routines.

The sensitivity of adherence to normative roles and routines (and deviation from them) is marked in the organization of this opening in terms of its activities, turn taking organization and in the interactional resources that participants deploy. This opening is unusual because it largely turns around the issue of the doctor’s late arrival. The usual opening activities are largely displaced by actions relating to his lateness, which is treated by both doctor and patient as something that makes an apology relevant. The opening begins with a noticing by the patient (lines 1-3) “op (. ) there ‘e is”, followed by a pause as the doctors enter the space. This noticing orients to the lateness of the doctors’ arrival.

The doctor treats the patient’s observation as drawing attention to something requiring apology. Consequently, the doctor’s initiation of a greeting sequence (line 5) is cut
short by the doctor himself as he launches immediately into an apology. This apology is accompanied with a smile, establishment of mutual gaze with the patient, and it is followed by laughter. Laughter has been established as a resource drawn upon by participants in medical consultations (and other situations) to deal with delicate issues (Jefferson, Schegloff & Sacks, 1987; Haakana, 1999, 2001, 2010; Zayts et al., 2010, 2017; Fatigante & Orletti, 2014), although most of the literature deals with issues of face affecting patients rather than doctors) and also as a strategy to encourage termination of a topic (Holt, 2016).

The patient in turn acknowledges and accepts the doctor’s apology (line 7) by assuring the doctor that the lateness has not been an imposition on him (“yeh no trouble”). The patient highlights the delicacy of the transgression by expanding his response to the offer of a (face saving) candidate explanation for the lateness using a declarative question (line 10) “busy day huh?” which the doctor affirms in a preferred, agreeing, response (line 12) before moving on to launch the business of the consultation core (line 16). Much of the discussion in this opening is accompanied by mutual gaze and smiling and punctuated by bursts of laughter.

Patients orient to the asymmetrical relationship between themselves and their doctors with regard to status for the consultation (in the inpatient hospital setting) and as well control over consultation timing in such teasing comments when the medical team arrives, such as: (see Extract 26, C11: P “here comes the cavalry”) or (see Extract 28, C40: P “the magi”). In these examples, the patients tease the doctors, highlighting their status at the top of the healthcare hierarchy by casting them as saviours and revered and powerful kings. In both cases, the patients’ teases are ambiguously ‘backstage’, occurring before the ‘official’ opening of the consultation but at a point when the medical team – the butt of the teases on both occasions – is entering the space and is within earshot. This has the effect of patients taking control of the agenda and challenging the asymmetrical distribution of interactional authority in favour of the doctors by speaking first and thereby effectively opening the consultation. In this way, patients’ teasing observations indexes a level of sensitivity or delicacy about the issue of the asymmetrical distribution of authority in
the consultation (Haakana, 1999; 2001; 2010; Rees & Monrouxe, 2010; Partington, 2006), thereby potentially displaying a sense of associated vulnerability.

In face-to-face interaction that occurs in the same physical space parties must come to occupy that space. They must become physically co-present, so that either both parties meet after travelling to the meeting point from other places, or one or more parties travel until he or she arrives at the interaction space (the ‘arriving party’ or ‘arriver’) where the other party is already present (the ‘pre-present party’), for interaction to be possible. The opening moments of a conversation are described in this way by Pillet-Shore (2008:17): “Arriving and pre-present parties become co-present. Arrivers can (1) seek to gain permission to enter from pre-present parties or (2) can self-admit …pre-present parties can choose whether and/or how to respond to summons”. They must then jointly coordinate the focus of their attention to a single point, thereby establishing mental (and potentially emotional) co-presence.

The central importance of establishing co-presence at both physical and mental levels is self-evidently relevant in all face-to-face interaction. In this way the bedside consultation is no different from consultations in other medical contexts, or most institutional and non-institutional settings. However, the way co-presence is established at the bedside is distinctive and unique in medical discourse, and consequently warrants attention in an account of how the bedside consultation is opened.

At the bedside, unlike during medical consultations in many other clinical settings, the patient is the pre-present party and the doctor (and medical team) is the arriving party/parties. This evokes a number of interactional imperatives, some distinctive that characterize this type of medical consultation, that participants orient to during the interaction. These include interactional asymmetries between participants, including distribution of (1) rights to shape and direct the consultation (including controlling the timing of its beginning and end), and (2) distribution of medical authority. Participants also orient to asymmetries in (3) ‘ownership’ of the consultation space, (4) in physical presentation and thereby location institutional
hierarchy (Jenkins, 2014). (5) The professional hierarchy is recurrently evoked in the manner of entry into the space by the medical team.

In contrast with what happens in other clinical settings, at the bedside, the patient usually awaits the doctor’s arrival (and that of the accompanying medical team) in the consultation space. This contrasts with the pattern documented in other medical settings, where the patient normally arrives in the doctor’s space, and it highlights a range of characteristic and unique interactional asymmetries.

In some consultations, participants (usually patients) overtly orient to this aspect of the organization of the consultation (the fact that they must wait for the doctors), recurrently using playful or ironic or joking references to the doctors.

**Extract 11  Becoming co-present (C5)**

1. D  Hello::: ((D enters space, followed by the team))
2. P  =Hello:
3. P  we’ve [been waiting ]
4. D  [Good mor::ning]  
5. P  (.)
6. with bated breath
7. (.)
8. for you
9. D  Oh:::
10. D2  ((Heh heh waiting with bated))
11. D1  Hi Mrs West
12. P  [Hello]
13. D1  [How are you?]
14. P  I’m very well
16. D1  You look well ((students enter space))
18. (0.1)
19. D  Now.
21. (.)
20. you haven’t had a blood test? have you.((D bends toward P, deictic finger gesture; looks at P, P looks ahead))

In Extract 11 above, as the medical team arrives in the consultation space (a single room), led by the lead doctor, the encounter is begun by a greeting sequence (lines 1 and 2), initiated by the doctor.

Immediately following the greeting sequence, the patient initiates a registering action in the form of a playful/joking telling (lines 3, 6 and 8) “we’ve been waiting (.) with bated breath (.) for you”. In Chapter 4 we see that doctors
treat a situation where patients initiate activities or actions as dispreferred, and in this example, the doctor similarly initiates a greeting sequence (line 4) that overlaps the patient’s informing in line 3. There is a brief pause (line 5) after which the patient continues with her informing action, in turn omitting a second part response to the doctor’s greeting first (line 6 and 8). In persevering with her action, pressing on to complete it despite interruption, the patient asserts her agenda of joking, informing and possibly veiled complaint, and her determination to be heard and to be active as a participant in the interaction.

At the completion of the patient’s informing, the doctor produces, as a second part response, the news marker/change of state response token “oh::” (line 9). The token is prolonged, suggesting the possibility of something more, however, the doctor omits further elaboration, thereby treating the patient’s informing as complete. In treating the informing like this, the doctor leaves any hint of a delayed arrival (potentially encoded in “we’ve been waiting”) unaddressed.

At this point other members of the medical team initiate an inserted greeting sequence that is preceded by a background mimicking of the patient’s informing by one member of the team (line 10) which (the mimicry) is truncated in an action of self-repair. This unusual breach of politeness norms is treated as dispreferred by other members of the team who continue on with the consultation by initiating a greeting sequence (line 11) rather than respond to the mimicry in line 10.

Earlier, we saw evidence that the topic of the medical team arriving late and/or keeping patients waiting is treated as a delicate issue. This evidence included patients explicitly referring to their experience of waiting a long time for the doctors to arrive, which was illustrated in Extract 10 (C15). In Extract 11 (C5) the topic of the patient’s playful registering action is the experience of waiting for the team to arrive. In this instance also, the patient’s reference to this topic is treated as delicate in two ways. The doctor responds to the patient’s registering informing with the dispreference marker “oh” at line 9.
In addition, a junior doctor mimics the start of the patient’s registering comment, through laughter (line 10) in an action that is unusual and is treated as dispreferred by the junior doctor himself who as an action of apparent repair, discontinues the utterance after two words. Such an imitation of a patient’s utterance is likely to have been treated by the doctor as dispreferred because it contravenes politeness norms. The patient’s registering comment refers to the experience of waiting for the medical team to arrive, with the possible implication that this waiting period has been longer than expected. In Extract 11 (C5), the topic of doctors keeping patients waiting is treated as delicate, and in this example, the doctor responds with the news marker and dispreference marker “oh:::”.

The patient in this consultation (Extract 11, C5) playfully/jokingly refers to the fact that she has been waiting for an unspecified – but implicitly unexpectedly long – amount of time for the doctors’ arrival. The doctor ignores the patient’s initiation of the informing statement: ‘we’ve been waiting/ with bated breath/ for you’, instead countering by initiating a second greeting sequence (line 4). The patient in turn ignores the doctor’s greeting first part and instead resumes her interrupted informing that is delivered deadpan, as a possible joke. As mentioned above, in line 5 the doctor acknowledges the patient’s informing with the news marker and change-of-state token “oh:::”.

This observation by the patient could be seen as not only orienting to her state of waiting for the doctors (who on their part kept her waiting) but could also be seen as small talk or pleasantries that were contributing to aligning the focus of the participants.

In Extracts 12 (C11) and Extract 13 (C40), patients acknowledge the arrival of the medical teams using teasing commentary (P: ‘Here comes the cavalry’, Extract 12; and P: ‘The magi’, Extract 13). In (jokingly) referring to the doctors as saviours (the cavalry) and as the Biblical Three Wise Men of the East (Matthew 2:1-6), these patients teasingly imply that they should be grateful that the doctors have come to see them, regardless of whether or not they have been forced to wait long for their visit.
The situation where the doctor is the ‘arriver’, and the patient awaits the doctor’s arrival, raises issues of ‘ownership’ of the consultation space, and well as of the distribution of rights to initiate action in the consultation. Participants demonstrably orient to both these dimensions of asymmetry.

Regarding ‘ownership’ of the interaction space, patients could be seen to orient to this issue by offering the doctor ‘hospitality’, thereby projecting a degree of ownership of the space. For example (Extract 14, C17 below):

Extract 14  Becoming co-present (C17)

1  D    Morning
2  P    Good morning (0.4) are you going to sit on the bed
3  D    No I'll stand here ((D smiles))
4  P    Are you sure?
5  D    Positive .(0.1)
6  P    Ooh sorry .(.)
7          try and (fit) through (.)
8  D    Now (.)
9          how are you?

The patient’s implicit claim to ownership of the consultation space may also orient to an ambiguous relationship between-doctor and patient in this space, where the distribution of authority is ill-defined. This relationship retains the asymmetry where
the doctor has epistemic and interactional control as well as acting as the agent of the hospital, and the patient is in a position of less authority and autonomy in these regards. In addition, the patient is in an intrinsically vulnerable position being sufficiently unwell to need hospitalization, with the associated emotional burdens of this.

By contrast, the patient is ‘the customer’ of the hospital and the recipient of the doctor’s professional care and services. In acceding to patients’ requests or directives, such as can be seen in Extract 15 below, the doctor may be orienting to possible patient vulnerability as well as to the ambiguity of this ill-defined relationship.

**Extract 15  Patient offering hospitality (C41)**

1. D  
   Now hello Mrs Fisher
2. P  
   (.)
3. D  
   I’ll just take a seat ((sitting down on a stool next to P))
4. P  
   Come a little bit closer ((P looks and gestures at D stool))
5. D  
   [How]((D moves stool closer to P))
6. P  
   How about that]
7. D  
   (0.1)((D completes stool move, settles, looks at P, who looks ahead))
8. P  
   How are you today

Conversely, when the doctor refuses the patient’s offer of hospitality as in Extract 14 (C17) above, he accompanies his refusal with a smile (line 3), and the patient’s offer is repeated in response (line 4). The patient’s response in line 4 treats the doctor’s smile (line 3) as possibly displaying ambivalence (rather than softening a dispreferred response) and providing an opportunity to repeat the offer.

The doctor’s smile on refusing the patient’s offer appears to display an orientation to the dispreferred nature of the response (a refusal). It may also orient to relative vulnerability of the patient, given the normative asymmetries embedded in the institutional doctor-patient relationship (discussed in §2.3.4) as well as possible additional asymmetries in this relationship in the inpatient setting (see §5.3.3).

When the doctor refuses the patient’s offer of hospitality a second time (line 5), he appears to display an orientation not only to the comfort or convenience of standing
rather than sitting to the bed, as well as to the asymmetry of the institutional doctor-patient relationship displayed in an embodied way with doctor standing and patient sitting or lying in bed. Another striking (and distinctive) aspect of asymmetry in this situation concerns the personal presentation of the participants in terms of their clothing worn for the consultation.

The impact and importance of clothing and physical personal presentation of participants in interaction is discussed in Chapter 2 (§2.3.8). Appearance, clothing and presentation turn out to be potentially powerful channels of embodied communication, albeit somewhat overlooked to date in interactional research. At the bedside, this aspect of communication is rarely overtly referred to by participants. It does, however, visually reinforce the contrasting institutionally-shaped roles of doctors and patients in inpatient consultations. Doctors occasionally wear traditional white cotton drill coats over their street clothes, and many members of the medical team have stethoscopes draped around their necks ready for use during physical examinations. Occasionally the leading doctor wears a white coat. Participants’ clothing is almost never the subject of discussion, but patients sometimes orient to the information it encodes (Jenkins, 2014) by applying makeup and brushing their hair prior to the doctors’ arrival almost certainly contributes to the roles and associated expectations participants orient to at the start of the consultation and throughout its course. At the opening, the manner of presentation of participants is not overtly oriented to but it may affect the way emotional co-presence is achieved.

The distribution of arriving and pre-present roles as described above below, where the patient is the pre-present party and the medical team members are the arrivers, is one of the aspects of the bedside consultation that marks it out as distinctive in structure compared with consultations in other medical contexts.

In the bedside consultation, the patient is invariably the pre-present party, and the members of the medical team are the arrivers who must enter the interaction space. Also, invariably, the medical team self-admit, and the patient is not in the position of being able to respond to a summons or a request to enter, and therefore does not have the opportunity to choose whether or not to permit their entry. This situation contrasts with that documented in primary and many secondary healthcare consultations, where
the patient must travel to the consultation room, where the doctor awaits their arrival (ten Have, 2007). When the patient visits the doctor in this way, it is common for the patient to request the doctor’s permission to enter by knocking on the door before entering, giving the doctor the chance (at least theoretically) to permit or deny permission to enter.

Bedside consultations are non-chance encounters in a public or semi-public space, and in all cases in the data in this study, arrivers in bedside consultations - the medical team - self-admit to the interaction space. The pre-present party, the patient, is expecting the doctors’ visit and awaits the medical team’s arrival. As the medical team arrives, the patient typically monitors the doctors’ arrival with gaze, while sitting or lying in bed, or sitting in a chair by the bed.

Entry by people into a physical interaction space inevitably involves moving their bodies into the area, followed by a process (however brief) of settling in. If placement is not predetermined, as for example may be the case at a formal dinner party where a table is set with place-names, or in a formal religious or vice-regal or other ceremonial or political event where places for participants to stand or sit are pre-allocated, then participants (“arrivers” (Pillet-Shore, 2008)) must find a place for themselves that seems appropriate and suitable to occupy, at least initially. This applies during the bedside consultation.

The arrival of the medical team at the beginning of a consultation is shown in Figure 12 below.
In this example (Figure 12), the leading doctor literally leads a procession of the medical team members into the patient’s room, physically embodying the hierarchy of relationships between team members for that consultation.

The manner of entry of the medical team to the consultation space often indexes its internal professional hierarchy in general and for that consultation in particular. The team usually enters in a procession, single file. The doctor leading that consultation generally enters at the head of the procession. Thereafter, the team generally enters the space in order of seniority, with medical students generally entering last. Here it appears that institutional structures organizing medical staff in the hospital find embodied expression in staff actions as they go about their work.

The size of the medical team varies depending on the type of consultation being undertaken, namely whether the consultation is part of a regular or a changeover ward round. When a changeover consultation is undertaken at the bedside of a patient in a six-bed ward, the space is very limited and can be very congested, with as many as six or more people attending.

Regardless of the amount of space available, most members of the medical team stand throughout the consultation. They usually orient their bodies towards the patient once
they reach their position. If space allows, the group organizes itself in such a way as to form two distinct groups. These groups consist of the doctor leading the consultation, the other attending doctors, medical students and occasionally others, such as dieticians. The medical teams in the bedside consultations in this study seldom contain nurses.

The activity of entering the space and finding a suitable place to stand is sometimes somewhat awkward in the confined area around a bed in a shared four-bed ward. This process often occurs silently, with all parties suspending speech and introduction of the first topic to allow time for the medical team to get settled in the space.

Doctors and patients almost invariably look at each other and smile during the establishment of co-presence, as the medical team enters the interaction space, occurs almost invariably at the bedside. During the establishment of co-presence in consultation openings, smiling is a recurrent feature of coming together and establishment of connection between participants and signaling of willingness to work together in interaction generally (Pillet-Shore, 2008). It is also regularly accompanied by the simultaneous establishment and maintenance of mutual gaze and also frequently (on 33% of occasions recorded by touching, chiefly hand-shaking).

5.3.2 Greetings, address terms and confirming patient identity

The opening of the bedside consultation almost invariably contains the linked activities of greetings and confirming patient identity.

5.3.2.1 Greeting exchanges

Greeting exchanges in face-to-face interaction are embodied versions of summons-answer sequences described at the beginning of telephone conversations (Schegloff, 1986), and are part of the ‘gatekeeping’ process through which potential parties to a conversation establish their viability as interlocutors. Greetings in face-to-face interaction are commonly delivered though speech and embodied actions such as waves, smiling, and establishing mutual gaze between interlocutors. Most consultations in this study begin with greeting sequences, which are generally (but not invariably) initiated by the doctor (89%, n = 40/45).
The activity of greeting is an early and important resource for helping participants to establish alignment, which is a key task of the opening and is arguably a pre-condition for mutually intelligible interaction. Alignment involves establishing mutual availability to engage such issues as the purpose of the conversation, the roles each participant will take for that conversation, and how authority to direct the interaction is to be distributed. Alignment is a state of explicitly or implicitly achieved mutual understanding and agreement between participants in conversation regarding the interactional terms of their conversation. Alignment can be seen as resulting from receipt of information but not access to the speaker’s stance about the issue (Stivers, 2008), and what Pillet-Shore (2008:4) describes as “orchestrating and coordinating a mutual re-orientation of their joint attention, focus and engagement so they may merge, mesh and synchronize – or come together – with one another” also articulates what I understand ‘alignment’ to refer to.

The form of the greeting sequence projects a particular relationship between participants in conversation. It indexes social distance, level of symmetry or asymmetry in terms of the nature of social relationship, including its level of formality or informality. The greeting sequence is therefore an important, if brief, activity that initiates participant alignment of perspective and focus for the conversation ahead.

The level of formality of the greeting encodes the affective distance of the relationship projected by the first speaker (usually the doctor).

**Extract 16  Greeting sequence (C24)**

1  P  Good morning
2  D1  Good morning

Greeting exchanges in conversation generally index the relationship between the parties in terms of ‘who’ the parties ‘are’ to each other for that particular interaction (Rossano, 2014), including their stance towards each other (Pillet-Shore, 2012). The lexical form of the greeting and its response help convey this level of meaning. Greeting forms at the bedside are most often more (than less) formal, whether initiated by the doctor or the patient. For example, “Good morning” was
more commonly used than “hi” or “g’day”. “Good morning/afternoon” occurs in 50% of greetings overall. This more formal format is slightly preferred by patients (who use it in 55% greetings they initiate) than doctors (who use it in 51% of greetings). This is true regardless of whether the greeting sequence is initiated by doctor or patient. This more formal, polite format projects a socially distant relationship between doctor and patient, consistent with a commercial or professional service provider/consumer relationship (Coupland et al., 1994).

The more neutral “Hello” is the next most used greeting form by both doctors and patients. “Hello” occurs in 34% of FPP greetings overall, with patients using it slightly more often (36%) than doctors (33%). This form projects a polite, neutral relationship that can be viewed as between service provider/consumer or persons with a distant social relationship, and/or an asymmetrical relationship with regard to distribution of interactional authority and/or professional knowledge. “Hello” projects an ambiguous mix of social and institutional ways of relating that characterize the relationship between doctor and patient in the medical consultation in general (Drew & Heritage, 1992; Coupland et al., 1994; ten Have, 1989), and also, as this study shows, at the bedside.

When patients initiate the greeting at the bedside, doctors usually produce a mismatched response and only occasionally respond with a matching greeting form. This lack of alignment in the formulation of greeting responses possibly constitutes a sanction against patients taking control of the consultation progression and timing by initiating the greeting sequence. 64% of doctors’ responses to patients’ greeting FPP are non-matching, with 18% SPP responses matching. However, the situation is reversed when the doctor initiates the greeting. Patients usually comply with the level of distance encoded in the doctor’s FPP ‘proposal’ with only a minority responding with a mismatched form. 63% of patients’ responses to doctors’ greeting FPP’s are matching, whereas 19% are mismatched.

These response patterns suggest that patients may be systematically more compliant to preferences encoded in doctors’ FPP greeting designs than doctors are with patients’
similarly encoded preferences. This may display an orientation by all participants to
the asymmetrical interactional order where doctors shape and otherwise direct the
interaction.

This is therefore the first systematic site of negotiation for control of the direction of
the interaction in the consultation. Taken together these patterns show participants
orienting to an asymmetry in interactional authority where doctors have the right to
decide when (and how) to launch a new activity. They also have the right to set the
tone of the consultation in terms of establishing the terms of the relationship between
themselves and the patients, as well as with the rest of the medical team (see also
discussion of introductions §6.2.4).

Doctors also initiate most greetings at the bedside, and most patient responses to
doctors’ FPPs are matching (e.g. FPP: ‘hello’, SPP: ‘hello’), such as that in
the example below (Extract 17, C44). In the example above (Extract 16, C24), the
patient initiates the greeting.

**Extract 17  Greeting and identification sequence (C44)**

<table>
<thead>
<tr>
<th></th>
<th>D</th>
<th>Morning Mr James</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>P</td>
<td>Good morning</td>
</tr>
</tbody>
</table>

Greetings are often (but not always) combined with address terms at the beginning of
bedside consultations. Addressing a potential conversational partner (and having the
‘identity check’ confirmed) is a further act of gatekeeping, and identity confirmation is
a virtually universal feature of face-to-face interaction across social and institutional
settings (Shegloff, 1986; Sidnell, 2010).

Forms of address further index the projected relationship between speaker and
addressee in conversation in terms of their respective roles for this occasion and in
terms of the associated social distance and level of formality. In these ways form of
address helps partners in conversation convey who they are to each other for that
casion (Schegloff, 1968; Sacks, 1989; Rendle-Short, 2007).
Identification or recognition sequences (Schegloff, 1986) occur at the bedside and fulfill parallel purposes. First, they perform the gatekeeping function discussed above, by confirming the appropriateness and availability of the parties for conversation (in this case consultation). In this context, the greeting and recognition sequence is both an interactional and an administrative task. Identity confirmation sequences also play an important role in developing the sense of who the parties ‘are’ for one another in this context, chiefly by means of the forms of address used (and not used).

**Extract 18  Greeting and identification sequence (C3)**

1  D  ((D enters, walking briskly, looks toward P and smiles))
2  P  Hello Col ((MG established))
3  D  Morning Brian! ((puts pen in shirt pocket))
4  (2.0)  ((team arrives, D pulls curtain around the bed as this happens))
5  P  hullo:
6  (.)
7  D  we’re being videotaped as you know

In Extract 18 above, the senior doctor enters the ward and walks briskly towards the patient, who is facing the entrance to the ward. The orientation of the doctor’s and patient’s bodies and faces (and the doctor’s gaze) during the doctor’s entry to the space are shown in Figure 13 below. The doctor looks at the patient and smiles as he enters. There is no footage showing the patient’s face, but his face is oriented towards the arriving medical team, so it appears that the doctor establishes mutual gaze with the patient as he enters the space. The fact that the patient initiates the greeting sequence during the doctor’s arrival, suggests that the patient is looking at the doctor as the doctor looks at him.
The patient addresses the doctor by his first name as the doctor enters the space (line 2). In doing so, the patient orients to a relationship with the doctor that is pre-established (the patient knows the doctor’s first name), relaxed (the patient addresses the doctor by his first name) and symmetrical in terms of distribution of rights to the floor between doctor and patient (the patient initiates the greeting sequence).

The doctor displays a similarly friendly and familiar orientation towards the patient by responding to the patient’s first pair part without delay (line 3), addressing the patient by his first name, looking at the patient and smiling. The doctor’s mismatched greeting formulation (the more formal and socially distant [“good” “morning”]) can be seen. Alternatively (and more likely), the doctor’s choice of a more formal address form may invoke the institutional relationship between he and the patient, and display a shift away from a socially framed settling in preamble to the task-focused business of the consultation proper.
In line 6, after the arrival of the team and preparation of the space (line 4), all of which takes a full two seconds, the doctor restarts the greeting sequence, looking at, and with his body oriented towards the patient. He uses the matching formulation of “hullo” to greet the patient, resetting the greeting sequence as aligned with the patient’s first part (line 2), and signaling a transition to business. This re-start of the conversation after a substantial lull in conversation during which other arrivers (the medical team) entered the space and settled in, would be unusual in other clinical settings or in ordinary social contexts. It consequently appears to be a pattern of interaction opening that is distinctive to this inpatient setting, indeed to the bedside consultation.

Extract 19  Greeting and identification sequence (C34)
((Doctor walks briskly into consultation space, leading the medical team. He looks at the patient and smiles, and the patient looks at the doctor and smiles.))

1 D Good morning Mr Lester ((mutual gaze and smiling))
2 P (.) ((doctor reaches out to pull curtain around bed))
3 D Good morning [How’re you this morning ]((turns back to face team))
4 P [Good morning. ] one and all ((smiling & looking at team))
5 D Now you’ve met ((points at Greta, turns back to look a patient)) Greta before who’s one of our [students]
6 P [Yes] ((looking at Greta, smiling))

In Extract 19 above, the (junior) doctor initiates the greeting sequence, using the polite “good morning” formulation that orients to a polite, relatively distant (although not unfriendly) professional relationship. This orientation is reinforced by the relatively formal, polite address term used for the patient, “Mr Lester” (line 1). The patient displays an orientation to the same polite, professional relationship by reflecting the doctor’s polite greeting form “good morning” (line 3). He also omits an address term for the doctor, something that is common across the data in the study. It was not clear whether the reason for this omission is that the patient doesn’t know the doctor’s name or that he chooses not to use it.

The patient’s second greeting at line 5 responds to the arrival of the medical team. Like the first greeting (line 3), the second greeting is polite, but its formulation is not a typical greeting (not ‘type conforming’). By acknowledging the team’s arrival with
‘[good morning] one and all’ the patient makes relevant the activity of introductions that the doctor omitted before asking the patient ‘how’re you this morning’ in line 4. The doctor subsequently launches introductions in line 7. By pre-empting an omitted activity (introductions) in this way, the patient displays a level of interactional control that does not normatively ‘belong’ to him, effectively sanctioning the doctor in doing so. In this way the patient asserts himself by taking control of the consultation’s trajectory at this point. By responding to the pressure to launch introductions embedded in the patient’s action, the doctor displays an acceptance of this demonstration of authority.

### 5.3.2.2 Address terms

Address terms are used in different ways in interaction. Their role in medical consultations is not widely documented in the literature and is therefore not well understood. However, based on what is known about patterns of address terms used in primary care consultations (West, 1984), the bedside consultation has comparatively distinctive patterns that may reflect its unique interactional needs and challenges.

Although the results reported by West (1984) refer to consultations recorded over thirty years ago, there is little else in the literature to use as a point of comparison, so I include them with the acknowledgment that the patterns she describes may no longer be relevant, and also that the current study relies on only a single, small data set. However both contribute to our understanding of possible patterns of use of address terms in medical consultations. The comparison between patterns reported by West (1984) and in my own data, as well as more detail about patterns in the current study are shown in Table 5-3 below.
Table 5-3  Address terms used at the bedside and in primary healthcare settings

<table>
<thead>
<tr>
<th>Address form</th>
<th>Patient to doctor, % Bedside (Rouse, 2018) n (consultations) = 44</th>
<th>Patient to doctor, % Primary healthcare (West, 1984) n (consultations) = 21</th>
<th>Doctor to patient, % Bedside (Rouse, 2018) n (consultations) = 44</th>
<th>Doctor to patient, % Primary healthcare (West, 1984) n (consultations) = 21</th>
</tr>
</thead>
<tbody>
<tr>
<td>No name</td>
<td>81</td>
<td>71</td>
<td>3</td>
<td>67</td>
</tr>
<tr>
<td>First name</td>
<td>14</td>
<td>0</td>
<td>33</td>
<td>24</td>
</tr>
<tr>
<td>Title (e.g. Mr/Mrs/Doctor X)</td>
<td>0</td>
<td>14</td>
<td>33</td>
<td>6</td>
</tr>
<tr>
<td>Sir</td>
<td>0</td>
<td>14</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Doctor</td>
<td>5</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>100</td>
<td>99</td>
<td>100</td>
<td>97</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Address form</th>
<th>Patient to doctor, % Bedside (Rouse, 2018) n (consultations) = 44</th>
<th>Senior doctor to patient, % Bedside (West, 1984) n (consultations) = 26</th>
<th>Doctor (overall) to patient, % Bedside (Rouse, 2018) n (consultations) = 44</th>
<th>Junior doctor to patient, % Bedside (West, 1984) n (consultations) = 18</th>
</tr>
</thead>
<tbody>
<tr>
<td>No name</td>
<td>81</td>
<td>40</td>
<td>32</td>
<td>22</td>
</tr>
<tr>
<td>First name</td>
<td>14</td>
<td>26</td>
<td>33</td>
<td>33</td>
</tr>
<tr>
<td>Title (e.g. Mr/Mrs/Doctor X)</td>
<td>0</td>
<td>32</td>
<td>33</td>
<td>45</td>
</tr>
<tr>
<td>Sir</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Doctor</td>
<td>5</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
</tbody>
</table>

Note: For some unspecified reason, West (1984)’s data do not add up to 100.

There are clear patterns in participants’ use of address terms during the consultation opening at the bedside. Doctors address patients directly by name in some way at the beginning of the consultation in a majority of consultations. This occurs in 66% (n = 31/44) of consultations. This may reflect the fact that doctors bear a dual administrative and interactional responsibility for confirming the patient’s identity before the beginning of ‘official’ medical business, as well as the
professional responsibility for re-establishing a trusting and respectful relationship with the patient to set the foundation for an effective consultation.

Patients, however, seldom return doctors’ direct address by addressing them directly (by name) in response. Instead, patients generally treat the doctor’s address as an action of identity confirmation. To do this, patients appear to tacitly confirm doctors’ attempts to (correctly) name the patient by failing to correct or contradict the attempts. Patients directly address doctors (by name) on 14%, (n = 6/44) of occasions. They fail to directly address the doctor by name in 82% (n = 37/44) of openings, and occasionally they address the doctor using a professional title (‘doctor’) (5%, 2/44). Patients seldom treat the doctor’s address as an invitation to produce a second part address term (for example also attached to a greeting). This may reflect the fact that patients sometimes do not know or remember the doctor’s names. Alternatively, it may convey an understanding by the patient that the doctor is performing a unilateral administrative action involving identity confirmation that is not expected to be reciprocal. In other words, in not addressing the doctor by name, the patient may be signaling an understanding that the doctor needs to confirm the patient’s identity but that this identification procedure is not reciprocal. It is not necessary for the patient to signal recognition of the doctor’s identity in the same way. Future research could investigate address terms in other medical settings for comparison.

The address terms used to confirm the patient’s (or doctor’s) identity index an understanding of the nature of the relationship between doctor and patient, or ‘who’ they ‘are’ for each other on that occasion, in a similar way that the form of greeting conveys a similar set of understandings. Doctors in general show a clear preference for using a formal or polite form of address to patients in the opening over an informal one. However, there is a difference in the use of address terms used by senior and junior doctors, as shown in the Table 5-3. Doctors address patients using more polite, formal terms such as ‘Mr Jones’ on 38% (n = 17/44) of occasions, and more informal address terms (e.g. ‘John’, ‘Mary’) on 29% (n = 15/44) of occasions. Doctors are, however, almost as likely not to address the patient by any name as they are to use an
informal address term. On a third of occasions (33% or n = 15/47), the
doctor does not address the patient by (any) name.

On the relatively few occasions when patients address doctors directly by name, they
strongly prefer using more informal address forms (e.g. ‘Sally’ or ‘Peter’), than more
formal forms (‘Dr Bowen’, ‘doctor’). Evidence of a lack of expectation that the
patient will address the doctor by name occurs when a patient launches a telling during
the opening of a consultation (C35) using a summons prefaced with the doctor’s name
as the he points towards the doctor. The doctor responds: “You’ve got a good
memory” as he smiles, maintains mutual gaze with the patient and steps forward
towards the patient. The patient responds to the doctor’s action by smiling, before
launching a telling about medical feedback he has received since the last visit.

The preference that doctors show for using more formal address terms for patients over
informal address terms, or for not addressing the patient at all, possibly marks their
understanding of the bedside consultation as institutional in different ways. First, a
formal form of address indexes a polite, professional relationship that has the character
of a service encounter (ten Have, 2006, 2007; Robinson, 2003, 2013). Although
identity confirmation is a feature of ordinary conversation as well as institutional
interaction, in the case of medical consultations, it has a particularly institutional flavor
because of its administrative purpose of ensuring that the correct patient is seen and
treated.

When doctors do not address the patient by name at all, this may show that they
feel sufficiently confident of knowing the patient’s identity to not have to confirm it
during the consultation. This confidence may come from a combination of having
read the case notes in advance, and (importantly) from having an ongoing, previously
established relationship with the patient sufficiently strong that the doctor
recognizes the patient by sight and doesn’t feel the need to confirm his or her
identity.

There is some evidence of a professional socialization effect when forms of address
for patients chosen by senior and junior doctors are compared. Part of the experience
of accompanying senior doctors on their daily ward rounds for junior doctors is that not only do they see clinical skills demonstrated by experienced clinicians, but in a more general way they see how experienced clinicians ‘do being a doctor in a hospital on ward rounds’ and are thereby socialized into these aspects of ‘being’ a doctor. That said, there are notable differences in the way some aspects of interacting with the patient at the bedside are done by junior doctors and seniors.

Junior doctors are less likely to not use any form of address to the patient than senior doctors. Junior doctors omit any form of address on 22% (n = 4/18) of occasions compared with senior doctors’ 41% (n = 11/27). This may project a greater degree of confidence felt by senior doctors in displaying recognition of the patient using address terms than is projected/displayed by junior doctors. The lower rate of junior doctors omitting an address term when greeting patients may display a wish to appear polite and respectful to patients and to their supervising senior doctors. In this way it may display/indicate junior doctors’ awareness of their relative lack of experience, and their choice to include all steps performing tasks in the course of their jobs. It could also reflect different training received by younger doctors where more emphasis is placed on acknowledging patients and displaying overt signs of respect to them.

Senior doctors use both informal and formal forms of address for the patient less often than junior doctors do. This confusing-sounding result is because senior doctors address the patient using no name more often than junior doctors do. They address patients by name during the opening (using either formal title or first name) more often than they ‘address’ them using no name.

Junior doctors address patients using informal terms (e.g. ‘John’, ‘Mary’) a third of the time (n = 6/18), whereas senior doctors use informal address terms 26% of the time (n = 7/27). Junior doctors address patients using formal terms of address almost half the time (44%, n = 8/18), whereas senior doctors address patients using formal address terms only a third of the time (33%, n = 9/27).

As part of the administrative dimension of the consultation, doctors (more than patients) orient to the need to confirm the patient’s identity. They typically do this by
using the patient’s name when greeting them (as discussed above). The address term doctors used to confirm patient identity simultaneously indexes the nature of the relationship between themselves and their patients and a projected degree of social distance separating (or linking) them for the occasion of the consultation.

Naming establishes rapport between conversation partners (Coupland et al., 1994) and the form of the name chosen (if a name is used) sets parameters of social distance and formality between them. As mentioned above, doctors at the bedside usually address patients by name (in 66%, n = 31/44) of consultations), which as well as fulfilling an identity checking purpose displays an acknowledgment of the patient as an individual rather than as an anonymous, generic patient.

Doctors address patients by their first names just over a third of the time (33%, n = 16/44). There is some variation between doctors in the level of formality encoded in their chosen address term. Against this, patients seldom address doctors by name, positioning themselves as recipients of a kind of greeting substitute where no reciprocal personal address term is necessary, appropriate or possible. This contrast in naming practices embodies an asymmetry that characterizes the interaction in different ways throughout the consultation and has been shown to be characteristic of doctor-patient interaction in general (Pilnick & Dingwall, 2011).

5.3.3 Settling in and registering

‘Settling in’ and ‘registering’ fall into the category of ‘dispositional talk’ (Coupland, Robinson & Coupland, 1994) and are activities recurrently conducted during the opening of the bedside consultation. These two opening activities are clearly related and often overlap rather than occurring sequentially (Pillet-Shore, 2008), and for this reason I include them in a single section in this chapter. ‘Settling in’ is the activity where participants *prepare themselves and the interaction space* for conversation using spoken or embodied actions (Pillet-Shore, 2008). Participants in conversation use settling in to align the focus of their physical and mental attention, disengaging from prior involvements and engaging with each other and space of the current interaction as it begins.
At the bedside, the terms ‘settling in’ and ‘registering’ refer to talk between and/or embodied action performed by the patient and doctor and/or members of the medical team that occur during the consultation opening at the bedside as part of the process of developing sufficient alignment and trust to begin its medical work. They are actions by which participants ready themselves for the forthcoming conversation in ways other than those discussed in other sections of this chapter. Other preparatory opening activities discussed in this chapter include greeting, checking identity, introducing, howareyou inquiries. In this section ‘settling in’ and ‘registering’ sequences that occur during the opening of the bedside consultation are described, discussed, and exemplified from the data, and I show how these actions display distinctive features of interaction in this clinical setting.

Settling in is a distinct interactional practice achieved through verbal and/or nonverbal actions by a sole participant or by two or more parties, cooperatively. Settling in actions include acknowledging or welcoming acts or utterances by pre-present parties offering refreshments or ‘welcome’ utterances, self-preparation such as self-grooming actions by either/any party, removing excess clothing (e.g. coats), putting down parcels, actions by arriving parties such as proffering gifts to pre-present parties, preparing the interaction space for conversation with or without accompanying commentary, declarations “or inquiries about expected participants” (Pillet-Shore, 2008:32) and participants finding suitable positions to occupy for the interaction. Because of its role in helping participants in conversation ready themselves for interaction and align their attention and physical and mental focus for conversation, settling in is an important part of the interaction opening without which coordinated communication is difficult or impossible.

‘Registering’, by contrast, is an activity that occurs during a conversation opening where participants make spoken reference to some aspect of the environment that they currently both occupy as part of the process of establishing mutual alignment, a sense of common ground, and trust before beginning the main work of their conversation (Pillet-Shore, 2008). While settling in involves preparing the mental and physical space for conversation, ‘registering’ involves the active identification of ‘things we have in common’, as a way of explicitly seeking out common ground and thereby
expressing goodwill and affiliation. The distinction between them is maintained here to show the subtle range of ways participants at the bedside prepare for the consultation.

At the bedside, settling in actions highlight distinctive features of this kind of consultation opening compared with previously documented medical consultations in other settings. Unilateral settling in actions at the bedside include welcoming actions and utterances by the pre-present party (the patient) ‘playing host’, self-grooming (mostly by patients), and finding a place to occupy for the consultation (by the doctors). The medical team finds places to sit or stand for the consultation rather than the reverse as occurs during the start of medical consultations in other contexts. In outpatient settings, patients routinely enter the consultation room where the doctor awaits their arrival, and the patient must find a seat and settle him or herself in to the interaction space.

Bilateral settling in activities at the bedside can include cooperative preparations of the physical space, helping the patient into a chair, opening or closing doors and rearranging the furniture or furnishings. The medical team sometimes rearranges the furniture (such as chairs, tray tables or adjusts the angle of the patient’s bed) or other aspects of the interaction space (such as drawing the curtain around the patient’s bed) to prepare for the consultation. This situation contrasts with that in an outpatient clinic consultation where furniture is in place before the consultation begins and does not require re-arrangement.

The opening of the medical consultation is not unlike that of the opening of other business meetings (ten Have, 2006). It is characterized by the doctor acting as host to the patient as he or she enters the interaction space. In primary or secondary healthcare settings, the interaction space is usually a consulting room. At the bedside, however, this dynamic is reversed, and it is the patient who occupies the role of host or at least resident of the interaction space and enacts that role by overtly ‘playing host’. This is a feature that distinctively sets the bedside consultation apart from previously described medical consultations.
When this happens, the patient ‘offers hospitality’ in the consultation space around the bed to the doctor and/or the medical team as they enter the space. The patient’s offer at the beginning of the consultation constitutes a kind of claim of ownership over the space for the consultation, treating the medical team as guests. In general, this situation, is likely to be framed as a yes-preferring offer by the patient. This thereby pressures the recipient to accept, with the additional implied relevance of thanks (for an offer). Acceptance of the offer by the doctor/s implicitly displays acceptance of the patient’s ownership claim of the space and associated rights to offer hospitality.

An example of a patient offering hospitality in the data from this study is illustrated in Extract 20 (C17) below, where the patient offers ‘hospitality’ to the doctor, with the yes-preferring polar question: “are you going to sit on the bed?” In this instance, the patient’s hospitality-offering question (line 4) is framed as information eliciting (“are you going to sit on the bed?” rather than “would you like to sit on the bed?”). This allows the doctor to resist the positive valencing of the patient’s question (i.e. yes-preferring) and provide a dispreferred ‘no’ response (line 5), softening its dispreferred character with a smile and an elaboration (line 7), without violating politeness norms to the extent that refusing an unambiguous offer of hospitality would do. That said, the doctor orients to the dispreferred and potentially face threatening nature of his dispreferred response in two ways. First, he produces two ‘no’s at line 5, which – multiple sayings - Stivers (2004) shows can be a strategy for projecting sequence closure. The doctor follows his declination of the offer with an account of the reason for it (“I’ll stand here”), accompanied by a smile and mutual gaze (line 7).
In this example, the patient deploys embodied and verbal resources to offer hospitality to the doctor as he enters the consultation space. However, the patient’s offer of hospitality implicitly raises issues other than the simple offer of a seat on the bed to the doctor. The patient utters a first pair part (FPP) request for information (line 4), using a yes-preferring polar interrogative question design. She gives her question additional force by maintaining mutual gaze and pointing to a space on her bed. In Line 5, the doctor produces a second pair part (SPP) dispreferred answer (refusal), followed by a third part sequence-closing explanation/counter (“I’ll stand here”).

The patient refuses to ‘move on’ and pursues her (weakened) agenda by repeating her offer in an abbreviated form in line 9, again using a yes-preferring polar interrogative question. This question format allows the doctor to give a response that, worded (emphatically) positively, is structurally preferred because it conforms to the question constraints, nevertheless refuses to submit to the underlying agenda. Because the patient’s second question structurally directs the doctor to confirm his initial refusal (using the preference dimension of the question design), it can be seen as a face-saving attempt by the patient to accept rejection of her proposition.

At another level this exchange can be understood to reflect a characteristic feature of the bedside consultation opening, outlined above, namely negotiation of nominal ownership of the interaction space for the consultation. As observed above, in primary care medical consultations, the patient enters the doctor’s room and the doctor offers
the patient ‘hospitality’ (e.g. by offering him/her a seat) (Robinson, 1998). However in an inpatient setting the situation is almost exactly reversed.

In one sense, the patient does ‘own’ the interaction space for the time he or she is in the hospital, because he or she occupies it (and in a private hospital has paid to occupy it), and is thereby in a position to offer doctors and others hospitality. In another sense, however, because the hospital owns the space and doctors act as agents of the hospital as an institution, doctors can claim ultimate ownership of the space. In this tangle of relationships is the potential for occasional struggles for control between patient and doctor/s that can be expressed through and seen in the form and conduct of interaction.

![Figure 14 Pre-present party (patient) offering hospitality ('Are you going to sit down?') (C17)](image)

Registering’ is described as follows (Pillet-Shore, 2008:46):

“During co-present openings, speakers can deliver utterances through which they interactionally register some feature of the setting that they are ‘just now’ starting to share with their interlocutors – features that are available for mutual perception and experience. Through these registerings, speakers display themselves to be attending to the selected features, inviting or directing co-participants to also attend to them, thereby proffering these features for sequence expansion.”
Examples of topics of registering talk at the bedside are shown in Figure 16 below. Registering refers to spoken action and explicitly identifies areas of common ground and is a way of achieving affiliation and a sense of common purpose. ‘Common ground’ is the foundation of joint activity between people. It can be understood as that part of the ‘information we have about our surroundings, activities, perceptions, plans [and] interests … that we think [others] share with us’ (Clark, 1996:92). Common ground is something that people must establish early in an interaction as a way of indicating to one another that they are fellow members of some kind of community. Highlighting such common community membership implies that the capacity exists for people to understand each other’s perspectives, are entitled to trust each other, and so have the basis of working intelligibly and cooperatively together.

Registering at the bedside can be a vehicle for doing things in addition to highlighting common ground in the service of achieving affiliation before beginning the medical work of the consultation. Patients can use registering as a resource for exercising agency (for example by jokingly highlighting a doctor’s lateness), and doctors can use it to display an understanding that patients may need or appreciate information or reassurance about such things as the hospital routine that may be unfamiliar and intimidating, or about the experience of being hospitalized with the uncertainty or fear that that may entail (for example by references to aspects of the hospital routine).

Some form of registering occurs in just over half the consultation openings in this study (56%, n = 27/48), usually in the form of tellings and (less often) requests for confirmation. Doctors initiate most registering actions (81% (n = 27), while patients initiate only 19%. Registering sequences often occur just after or during completion of settling in actions. The themes of registering sequences vary, and they refer to a variety of features of the consultation that are shown in Figure 15 below.
5.3.3.1 The form of registering actions

Doctors and patients use different structural forms to do registering at the bedside. Doctors rely on declarative statements to do registering (e.g. “This is normal for a Friday” (C21), “It’s camera action here this morning” (C10)), more often than patients do.

Table 5-3 Forms of registering actions.

<table>
<thead>
<tr>
<th>Form of registering action</th>
<th>Doctor % n = 22</th>
<th>Patient % n = 28</th>
</tr>
</thead>
<tbody>
<tr>
<td>Declarative question</td>
<td>77</td>
<td>21</td>
</tr>
<tr>
<td>Declarative statement</td>
<td>22</td>
<td>75</td>
</tr>
<tr>
<td>Polar question</td>
<td>0</td>
<td>4</td>
</tr>
</tbody>
</table>
Doctors use declarative statements for this action in 77% (n = 17) of occasions when they initiate registering, whereas declarative statements are the form patients use in 6% (n = 3) of occasions when they initiate registering sequences. Declarative statements are often used to launch tellings and make acknowledgment or acceptance relevant and preferred and contradiction dis-preferred.

The characteristics of preferred ‘packaging’ of registering suggest that speakers design their registering turns to mobilize agreement from and alignment in stance with recipients. This may be a strategy for projecting the relevance of establishing shared perspective.

Patients, conversely, rely proportionally more on declarative questions to do registering (e.g. P: “You’d think it was Paul Hogan wouldn’t you?” (C20)) than do doctors (e.g. D: “Sitting out of bed today?” (C13)). Patients ‘do’ registering using declarative questions in 78% (n = 21) of their registering actions whereas doctors rely on this form in only 22% (n = 5) of occasions. This form of question is most often seen in requests for confirmation, and therefore concerns something already known or strongly suspected. In this way, it appears to be an intrinsically affiliatory action because it is strongly positively valenced (making agreement relevant).

However, while doctors use declarative questioning as registering to comment on such things as where the patient is sitting (implying in the case of C13 above that the patient has made progress since the last consultation), patients often use declarative questions as invitations to laugh (see example above from C20).

When doctors initiate registering, they most often make references to external things such as the hospital routine, and frequently to some aspect of the experience of being filmed. When patients initiate registering, they more often issue invitations to laugh at the experience of being filmed or at some aspect of the doctor’s image or behavior.

Registering can take the form of commentary about aspects of the hospital routine, for example: (C47, C19: “this is normal for a Friday”, or C27: “all the
team is here”), about the weather (C45: “it’s not very nice out there”) or about being filmed (C1: “this is the first time we’ve done this”, C10: “it’s lights camera action today” C3: “we’re being videotaped, as you know”). Doctors are usually the ones to make these kinds of comments, and these are the main form of registering action initiated by doctors.

Registering can also take the form of invitations to laugh focused on the experience of being filmed (C45: “you’re famous!”, C24: “are you the make-up man?”) or on some aspect of the doctors’ behavior (C11: “you never called me that before”) role, or image “here comes the cavalry”, C40 “the Magi”). In keeping with earlier findings (Haakana, 2001), patients make registering remarks that take the form of invitations to laugh more often than doctors.

Laughter and joking in medical contexts are a strategy used to manage delicate moments (Haakana, 2001). When patients use invitations to laugh as registering actions, the focus of their comments are often some aspect of a potentially awkward in-common experience, such as being filmed (as part of this study). This framing of a ‘laughable’ as jointly recognizable and knowable is ‘bonding’ (Cortez & Boxer, 1997) and projects affiliation for the interaction ahead.

Registering actions referring to the experience of being filmed incidentally highlight the observer paradox, where people being filmed are aware of being observed. In addition, they orient to the relevance and importance of physical appearance, even in this hospital setting. It is notable that this kind of joke is invariably made by patients. The subtext of these jokes is that people being filmed want to ‘look their best’ and they may display patients’ awareness of and their own appearance and presentation in their situation as inpatients.
Laughter talk is a recurrent feature of bedside consultation openings in this study, occurring in 33% of them. Laughter and invitations to laugh in medical consultations have been shown to be resources for marking out common ground and establishing connection and affiliation as well as for managing delicate matters (Jefferson, 1989; Haakana, 2002).

Shared laughter displays affiliation (Glenn, 2003). At the bedside, laughter and invitations to laugh are usually acknowledged and responded to by the recipient (usually the doctor) with smiling and/or relevant evaluations or by further commentary on the situation. Such doctors’ responses display an understanding of the patient’s invitation to laugh as intending to mark out an area of common ground (possibly also to signal anxiety) and an associated willingness to cooperate in this co-construction of common ground.

**Extract 21  Patient initiated registering - invitation to laugh (C20)**

1  D  Hi
2  P  You’d think it was Paul Hogan wouldn’t you? ((heh heh heh heh))
3  (.)
4  D  I know I know
5  (.)(smiles))
6  it does put a little bit of stress on when we’re being filmed
7  (.)
8  now how are you feeling today?

The patient’s move to identify common ground in the form of the shared experience of being filmed by referring to a well-known satirical film, displays an understanding that being filmed in such a setting is potentially embarrassing, exposing or ridiculous (e.g. P: “You’d think it was Paul Hogan” in Extract 21 above).

The doctor’s response in this example, displays his agreement and acceptance of the proposition the invitation to laugh encodes (“I know I know”). However, while accepting the premise of the laughable, the doctor’s response repeating the assertion “I know”, simultaneously projects the relevance of terminating the topic, and progressing to another (Stivers, 2004). In case, the doctor’s response displays the relevance of terminating the settling-in topic and also of the consultation opening.
Registering is usually achieved using a mix of verbal and embodied resources, however on one occasion it is accomplished entirely nonverbally, with an eyebrow flash coordinated with a glance directed towards the camera, denoting reference to being filmed.

Registering has seldom been singled out as a feature of medical consultation openings in primary, secondary or other healthcare settings in the literature (although Collins et al 2007 report it in reference to homeopathic consultations), and its recurrence at the bedside and the fact that it highlights a characteristic feature of the bedside consultation (namely the marked social and often epistemic asymmetry between doctor and patient), makes it a distinctive feature of this kind of consultation opening. Future research could indicate whether registering is also an important part of medical consultations in other settings.

5.3.4 Introductions

Introductions are a distinctive and fairly frequent component of the bedside consultation opening, largely reflecting the multi-party nature of the consultation. In this way introductions distinguish the bedside consultation as unusual if not unique among medical consultations (see Paul, 2015’s account of genetic testing consultations in a secondary healthcare setting, where introductions also occur).

Introducing can be understood as “a sequence of actions through which participants explicitly identify self, and/or other” (Pillet-Shore, 2008:17). Introductions acquaint previously unknown people, or re-acquaint those who have previously met, marking their importance for that interaction, and implicitly invite their active involvement in the forthcoming conversation. They usually occur near the beginning of a conversation and contribute to the process of establishing trust and affiliation between participants and are relevant only once in a conversation, usually early, enabling the initiator to formulate a template of relationships between the parties. This is done by the way the parties being introduced are described or otherwise referred to. Introductions can be self-introductions or three-party mediator introductions.
The multi-party nature of the bedside consultation is highlighted by introductions. These are often distinctive to bedside consultations compared with consultations in other settings, and are made relevant by the involvement of a medical team rather than a single doctor. Of the consultations containing introductions, many have both kinds of introduction, but there are more three-party than self-introductions, while most consultations contain no introductions. Despite being activities that are distinctive in bedside consultations compared with consultations in other medical settings, they are not ubiquitous.

Although they occur in a minority of bedside consultations, introductions are less frequent during consultations in other clinical settings. They are relevant when parties have not met before or have probably not met before, and when they occur in community settings, the form of introductions differs from that of introductions in inpatient settings because consultations are seldom multi-party as are the consultations in this study, and so introductions in outpatient settings are unlikely to be third-party introductions as they most often are at the bedside. As such, introductions reflect aspects of the work of the bedside consultation that uniquely characterize this setting.

At the bedside, introductions often occur in conjunction with case presentations (see §5.3.6). The combination of introduction plus case presentation comprise a composite activity apparently unique to this setting. Doctors use introductions to present members of the medical team to the patient at the beginning of the consultation. However, case presentations do the reverse: doctors use them to present the patient to members of the medical team (and usually chiefly to a particular member of the team). For this reason, the introduction and case presentation recurrently function as an introductory unit that uniquely characterizes the early stages of bedside consultations. Although introductions occur early in a conversation, at the bedside they do not always occur during the consultation opening and are sometimes treated as part of the medical business of the encounter.

The introduction at the bedside can also mitigate a ‘presentational’ asymmetry that uniquely characterizes inpatient bedside consultations. An introduction is an overtly respectful action in a situation where the patient is in an inherently vulnerable and sensitive situation, as seen in Extract 30 (C34), where the patient displays an
orientation to the relevance of introduction. In that instance, the patient also uses a non-type conforming response (P: “good morning one and all”) that effectively (pointedly) re-do’s the initial greeting, thereby making an introduction relevant. It is possible that this is an example of the patient exerting agency and indirectly addressing the ‘presentational’ asymmetry referred to above.

The inpatient is bedbound, sick, in a public space usually lacking much privacy, engaging in a professional interaction with a group of people standing (where the patient is sitting or lying in bed), wearing street clothes (while the patient is in bedclothes). As Emerson (1973:362) comments with regard to the objectification of the patient that is to some extent unavoidable in medical work, and relevant in this situation: “This indignity can be cancelled or at least qualified by simultaneously acknowledging the patient as a person”. In addition to the relationship-building capacity of introductions in any interaction, at the bedside introductions have the capacity to orient to and mitigate the social/presentational asymmetry between doctor and patient that exists at the bedside. Given the pragmatic importance of the patient knowing who the doctor is, it is notable how often this is ignored by doctors, as seen in how infrequent introductions are at the bedside.

In the context of the bedside consultation, the introduction occurs with members of the medical team standing around the bed, occasionally with one doctor sitting next to the bed, or on it, and the patient usually in bed or, occasionally, sitting next to it. The bedside introduction usually acknowledges all participants, including those with peripheral roles in the consultation, and occupying relatively junior positions in the institutional/hospital hierarchy.

As a means of acknowledging relatively vulnerable consultation participants, including the patient and junior members of the medical team who will probably remain passive observers during the consultation, the introduction is important. Introductions also empower patients and give them the means of counteracting the asymmetries outlined above to some extent by giving them the implicit opportunity to accept (or refuse) the presence of observers. As mentioned in Chapter 5, consultations in this study occur as part of ward rounds involving a medical
team comprising between two and eight people, some of whom the patient may not
know or remember from previous visits. Team members may also not know the
patient. There may be people in the medical team who the patient has not met and
does not know, and vice versa, as well as some they do know. This is a situation that
seldom applies in consultations in other clinical settings, where only a doctor and
patient are involved.

Introductions occur during only a quarter of consultations in this study. Most opening
sections (73%, n = 33) contain no introduction. Introductions during
openings therefore occur in only about a quarter of consultations, and of these, almost
all (92%, n = 11, of the introductions) are three-party mediator introductions, and 8%
(n = 1) are two-party self-introductions only. 6% (n=3) of the consultations, and (20%
of the introductions) have both self-introductions and third-party mediator
introductions, where the doctor begins the introduction sequence by introducing him or
herself before introducing other members of the medical team to the patient.

Introductions take the form of either two-party self-introduction and three-party
mediator introduction or a combination of both. Stand-alone third-party
introductions are the main form of introduction used at the bedside, followed by the
combination of self-introduction plus third party introduction. Self-
introductions occur only rarely. 92% (n = 11) of introductions at the bedside are
stand-alone third-party introductions, 20% (n = 2) combined self-introduction with
third party introduction, and only 8% (n = 1) are self-introduction alone. This pattern is
consistent, with preferences for introduction type described in other general settings.
Pillet-Shore (2008) found that, first, “when a known-in-common person is present,
parties treat mediator-initiated introductions as ‘preferred’ over self-initiated
introductions; and [second] when launching introductions, offers of identifying
information are strongly preferred over requests” (Pillet-Shore, 2008:20 italics in
original).

This pattern is also consistent with what appears to be a key purpose of the
introduction at the bedside: providing the patient with the opportunity to meet the
medical team who would be caring for him or her before introducing the patient to the
medical team in a detailed, medically relevant way, in a case presentation. The
introduction also prepares the patient for the experience of participating in a consultation that takes place with an audience and from which he or she may be excluded at times, despite being the subject of the conversation. That is, at times during the consultation the patient can become witness to a conversation between members of the medical team, about him/her.

Introductions at the bedside have an internal structure and interactional make-up similar to but generally more limited than that described in other institutional settings (Coupland, Robinson & Coupland, 1994; Pillet-Shore, 2008). This structure incorporates some actions discussed separately in this chapter because they often occur independently of introductions (e.g. howareyous, greetings), as for example during consultations where there is no introduction. The actions in the ‘ideal’ introduction sequence may but do not necessarily all occur on a particular occasion or in the order they appear in the model below, because they are deployed by participants to satisfy the requirements of the local context. However, the first three items are essential components of the introduction (Pillet-Shore, 2008), and introductions may contain others of the following additional components:

1. Gaze-body coordination
2. Person reference formulation
3. Greetings as a ratification of information received
4. Repeated person reference formulations
5. Howareyous
6. Outlines of preexisting knowledge of persons
7. Assessments relating to the introduction and
8. Touch or body contact

At the bedside, the leading doctor (the known-in-common person) almost invariably initiates the introduction. Following an initial greeting sequence, the doctor usually introduces members of the medical team to the patient. The medical team (as discussed in §3.3) can include senior doctors, junior doctors, medical students, and nurses, and the doctor introduces team members (and often also him- or herself) to the patient, usually after an initial greeting exchange and sometimes after first introducing him or herself.

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As mentioned above, most introductions at the bedside are three-party mediator introductions, either with or without an initial self-introduction by the leading doctor. The only other kind of introduction in this data is the two-party self-introduction. In the following section I discuss examples of each of these from this data to show how they are conducted, and how they embody characteristic features of the bedside consultation.

Introductions during the bedside consultation clarify three key issues. They establish the identities of the patient (and any people accompanying the patient) for the doctor, of the doctor for the patient, and of any additional attendees such as family members accompanying the patient for the doctor (and vice versa) for the consultation. Introduction sequences also display relationships between participants in the consultation, including within the institutional hierarchy of the medical team. Introductions also establish the relationship between doctor and patient as either a previously established or a new relationship. In these ways, the introduction provides an opportunity for the doctor (who invariably launches introduction sequences) to establish a normative relational framework for the bedside consultation. Introductions can take the form of a single party self-introduction, where the introducer (in this setting, usually the doctor) introduces him/herself, of two-party self-introductions, where each party introduces him/herself in turn, or a third-party introduction, where someone known to both/all unknown parties, introduces the unknown parties to each other. In this situation, the doctor usually also conducts third-party introductions.

Introductions occur in 28% (n = 13) of consultation openings, and majority of these introductions are third party introductions, where the doctor introduces the patient to other members of the medical team. Self-introductions, where the doctor introduces him- or herself to the patient before beginning third party introductions, occur in 11% (n = 5) of the consultation openings in the study. This means that just over a third (39% or 5/13) of all introductions include self-introductions. The majority of introductions (77% or 10/13) occur during regular ward round consultations and fewer than a quarter (23% or 3/13) occur during changeover
consultations. Occasionally (4% of all consultations, n = 2), introductions are made after the main phase of the consultation has begun, or to put it differently, 13% of introductions (n = 2/15) occur during the business section of the consultation.

When introductions occur during a consultation, they occur in either the opening or the main section of the consultation. Apart from the location of the introduction in the structure of a particular interaction, the form of the introduction is similar, as is the interactional action it performs. Introductions can be treated as part of the activity of identification verification canonically belonging to interaction openings. Introductions can also be sequentially linked with case presentations when case presentations are treated as part of the core business of the consultation. For this reason, introductions occasionally occur during the consultation core.

5.3.4.1 Two-party self-introductions

In a two-party self-introduction, each party introduces themselves to the other in turn. This kind of introduction is rare at the bedside for two key reasons. First, when the usual participants are present (patient and medical team), it is not relevant for the patient to introduce him or herself to the doctors and medical team, because they already knew him/her (or knew about him/her). Self-introduction is therefore only relevant when a family member or unknown other is present, which is rare in this data. On most occasions when a family member is present, they are not introduced, and do not introduce themselves, and are usually only minimally acknowledged by the medical team.

In Extract 22 (C38), below, we see a rare instance where a family member introduces herself. In this instance an introduction exchange between the doctor and the patient’s daughter is not followed by further introductions involving the patient and the rest of the medical team. This is the sole example of a two-party self-initiated introduction in this data. It is very brief (four seconds’ duration) and occurred in a single room where the patient’s daughter is present along with the patient, as the four-member medical team arrives to conduct the consultation.
This introduction contains several canonical elements of the introduction structure described above. Embodied resources, particularly gaze and body orientation, are mobilized to conduct the introduction, as is body contact (in this case, hand-shaking – see Extract 22 below), greetings are intertwined with introductions, and person reference formulation is repeated.

The patient’s daughter introduces herself to the doctor as the medical team arrives, prompting an overlapping second part acknowledgment from the doctor (line 4: “nice to meet you”). The patient’s daughter follows the doctor’s acknowledgment with a third part sequence-closing assessment (“nice to meet you”).

The patient’s daughter’s self-introduction makes a subsequent self-introduction from the doctor relevant, which occurs in line 6, overlapping the end of the patient’s assessment. The doctor introduces herself using the informal option of her first name, however she does so in a minimal form (“Melinda”), overlapping the daughter’s turn, to which the patient’s daughter produces a second part acknowledgment (line 7) using a greeting with a repeated formulation of the doctor’s name (“hello Melinda”).

In initiating the introduction, as well as the greeting sequence (line 1), and thereby taking control of the consultation at that point, the patient’s daughter violates the normative interactional order whereby the doctor exercises the right to lead the consultation. Here, the doctor can be seen to orient to that norm by withholding a second part greeting after the daughter’s first (line 1), by producing overlapping responses to the daughter’s turns (in lines 4 and 6), and later producing a minimal self-introduction (line 6).
Extract 22  Patient’s daughter (PD) and doctor both introduce themselves (C38)

1 PD Hello
2 (.)((MG, D & PD smile, lean forward, shake hands))
3 [Danielle ] ((nods and smiles))
4 D [Nice to meet] you
5 PD Nice to meet [you    ]
6 D [Melinda]
7 PD Hello Melinda
8 D How are you today? ((turns gaze and body towards P, smiles, leans forward to shake P hand, P sits up and extends hand and arm to shake doctor’s hand))

The daughter’s assertiveness in this introduction sequence is unusual, as well as being the only example in the study data of a family member or advocate introducing herself to the doctors as they arrive. The daughter’s assertiveness sets the tone for a consultation where control of the encounter is contested more vigorously than usual by the patient or his or her agent.

Mitigating the norm-violating nature of the organization of this greeting and introduction sequence are the facts that doctor and patient smile at each other throughout, maintain mutual gaze, orient each other’s bodies towards each other and shake hands (touching being an optional affiliatory component of introductions in general, although relatively uncommon in this data). The deployment of embodied resources in the introduction is illustrated in Figure 16. In addition, the doctor, despite wearing a white gown that marks her institutional role and associated authority for the interaction, projects a friendly and relatively symmetrical relationship between herself and the daughter by referring to herself using her first name, as does the daughter.
5.3.4.2 Three-party mediator introductions

In Extract 23 (C27) below, the doctor begins the introduction sequence with a self-introduction (line 3). In ordinary conversation, self-introduction is treated as dispreferred (Pillet-Shore, 2008), and the patient’s response (line 4) is prefaced with the news marker “ah [hello Rosalie]” that has been associated with displays of resistance or dispreference. Turn initial “oh” has been categorized as a change-of-state marker (Heritage, 1984) indicating that the turn it prefaces is somehow out of alignment or “non-contiguous from what came just before”, and is misaligned from, or in disagreement with some aspect of it, or its content (Bolden, 2014:2-3).
Extract 23  Doctor introducing herself and the rest of the medical team (C27)

1  P  Hello  [lo ]
2  D  [Good] morning Margaret Bell
3  D  I’m Rosalie Cherry I’m one of the physicians here ((MG, slight
4  smile; stands by bed))
5  P  Ah hello Rosalie((MG; smiles, team enters))
6  D  The rest of the team ((hand gesture towards
7  them))are here ((turns body towards team; P looks at and
8  gestures hand towards team))
9  (.)
10  P  they’re going to join us
11  D  Oh
12  P  You know most of them I’d say?((turns back to face and looks at
13  P; P remains looking at team))
14  D1  [No   ]((smiling, looking at team))
15  P  [Hello]
16  D  Hello ((smiles broadly))
17  D  Dr Rogers ((points and looks at D1))
18  N  [Barbie   ]((turns towards, looks at Nurse))
19  N  [Hello ]
20  P  [Ah yes  ]I know that lady ((smiles, MG, points at N))
21  D  Okay.
22  (.)(turns back to face P)
23  D  now ((MG; P smiles))
24  (.)(closes eyes, turns back to and looks at team)
25  you know Lisa?((points at Lisa))
26  (.)(, turns back to P)
27  P  Yes. ((nods and smiles, looks at D2))
28  D2  Good morning
29  P  Good morning ((smiles))
30  D  And then Mary will be here soon ((looks at P))
31  P  Now all ((double hand palms up & out gesture))I want to know
32  is what they’re going to do to me today((D looks at P))

Extract 23 above shows a third-party mediator introduction, the most frequently occurring type of introduction at the bedside. Here, the leading doctor begins by introducing herself (line 3) before introducing other members of the medical team. In introducing other members of the team, the lead doctor does not describe their roles, only recounts their names.

The introduction sequence provides an opportunity for the leading doctor to sketch out the parameters of the relationships between the parties to the consultation, and of ‘who’ each participant ‘is’ to each other. The address terms the leading doctor uses for different team members she introduces implicitly locates them on the institutional professional hierarchy; senior doctors were referred to as “Dr X” (for example, line 17: “Dr Rogers”) whereas junior doctors and the nurse who is
present, are referred to by their first names (e.g. line 25: “you know Lisa?”; line 30: “Mary will be here soon”).

It is notable however that the leading doctor does not refer to herself as “Dr X” (line 3: “I’m Rosalie Cherry, one of the doctors here”), although she is a senior member of the team as well as being the leading doctor for that occasion, in her description of her role the leading doctor downplays its institutional importance (“I’m one of the doctors here”), italics added. This formulation projects a relatively symmetrical relationship between herself and the patient for the consultation, a proposition that the patient orients to in her response to the doctor’s self-introduction: “Ah hello Rosalie” (line 5).

In using varying person reference formulations for in introducing other participants in the consultation, the doctor uses the process of introducing the patient to the team as an opportunity to display the team’s institutional structure to the patient as well as acknowledging the individuals playing different roles within it and introducing her to them.

Figure 17 Three-party mediator introductions – mobilization of embodied resources during introducing: pointing and gaze establishing person reference
This introduction shows the importance of body orientation and gaze in moving the conversation forward (Pillet-Shore, 2008 above). An aspect of this during the introduction sequence in C27 is shown in Figure 17 above. The doctor orients her body and her gaze towards the current focus of her talk, so that when she is introducing each team member, her body and gaze are oriented towards the person she is introducing or addressing, and she usually also points towards the introduced party at the moment when she names each of them, before turning her body (and gaze) back towards the patient throughout the process of naming different team members. The doctor thereby creates an embodied link between the patient and the clinicians she is being introduced to. When the introductions have been completed, the doctor turns her body and gaze back to the patient, completing the introduction activity with mutual gaze. During this process of introduction, the patient gazes and smiles at the team members as they enter and as they are introduced.

Introductions may precede information-collecting activities such as verbal and physical examinations of the patient by the doctor, or they may be followed by a case presentation, and in this instance the introduction precedes the case presentation discussed in §5.3.6.

In this introduction (Extract 23, C27), there is evidence of misalignment between doctor and patient throughout the sequence. The introduction sequence is preceded by a misaligned greeting sequence initiated by the patient. The doctor gives an un-matching second greeting part in response to the patient’s first, with an overtly institutional form of address to the patient: “good morning Margaret Bell” (line 2). This is followed up immediately by the doctor’s self-introduction, again framed with an overtly institutional tone “I’m Rosalie Cherry I’m one of the physicians here” (line 3).

The patient’s response (line 4) contains several signs of misalignment of stance. The patient’s response to the doctor’s self-introduction is with a second part greeting that is the same as her initial greeting (“hello”) unaligned with the doctor’s “good morning” (line 2). The patient’s greeting is preceded by the dispreference marker “oh”, and she uses a more informal address term than the doctor uses,
addressing the doctor by her (the doctor’s) first name rather than using the information provided to address her more formally as “doctor” or “Dr Cherry”.

The discussion of the introduction represented in Extract 23 (above) and shown in Figure 18 illustrates the interplay between speech and embodied communicative resources. Gaze-body coordination, person reference formulation, greetings, assessments relating to the introduction are deployed in a coordinated manner to accomplish different aspects of the activity of conducting introductions.

The doctor’s self-introduction is treated as dispreferred by the patient’s use of the turn-initial discourse marker “oh” that precedes her greeting response to the introduction. The patient exercises agency and possibly continued misalignment in contradicting the doctor’s assertion that (line 12) “you know most of them I’d say” by giving a dispreferred response (line 14) “no”.

It is also evident that a number of items of the work of the opening is being done in and through the introduction in this consultation. These includes identity checking, greeting, establishment of common physical and attentional focus, and assertion of patient agency.
In contrast to Extract 23 (C27), the form of the introduction shown in Extract 24 (C24) above conforms to *preferred* forms of introducing, so there are no markers of dispreference or discontinuity. The introduction contains the mandatory introduction features of gaze-body coordination, person reference formulations (e.g. Line 221
“this is Dr Roberts who is our geriatrician”) and greetings. The doctor positions her body perpendicular to both patient and medical team and swivels her head and gaze from one to another as she makes introductions, also using deictic (pointing) arm gestures to refer to the doctors she is introducing them, one by one.

Extract 24 contains features that characterize many introductions in this data: forms of greeting and address participants use, management of interactional progressivity (i.e. ways of ensuring that the consultation continues to progress through the activity rather than getting stuck or bogged down in the current activity), and ways of linking different components of the introduction together into a single coherent overall activity. The terms used by the introducing doctor to refer to the team members she introduces (person reference) reflects their seniority in the institutional hierarchy. Junior doctors are referred to by their first names, while senior doctors were referred to by their job titles ("Dr Roberts", "Dr Yates") and by additional information about them ("our geriatrician", "he’ll be on for next week").

All introduced parties (team members and patient) greet each other during the introduction, either verbally and/or in an embodied fashion, by smiling, or waving. In all cases, mutual gaze is established between the parties being introduced. Patient responses to the doctor’s introductions in this example are unhesitating and preferred (Line 12: "good morning"), supporting claims that this form of introduction is unproblematic, and in an inpatient consultation context as well as in other social and institutional contexts reported by Pillet-Shore (2008).

Progressivity in the introduction is achieved with discourse markers separating actions. “So”-prefacing signals other-attentive topics, and is also sequence-initiating (Bolden, 2006; 2009). The doctor uses “so”-prefacing to introduce someone after a unit of explanatory information had been delivered (Line 8: “So you know Madeleine”, Line 18: “So this is Dr Yates”). When and- prefacing appears as a feature of question design it has been shown to be a way of maintaining activities across sequences (Heritage & Sorjonen, 1994), and also to
signal the wish to bridge small gaps in interaction (Turk, 2004). In C24 (Extract 24 above), each introduction after the initial introduction and that/those following an initial (Line 10: “and you know Peter?”, Line 13: “and Dr Yates is here”, Line 20: “and this is Dr Roberts”) link each new introduction to the last in an activity that comprises a composite introduction of several linked but individual introductions.

The impact of body orientation and occupation of space on engagement and disengagement during interaction in general and in medical discourse in particular has been documented in earlier research and can be seen in this study data (Robinson, 1998; Heath, 1981). Robinson describes bodily movement being used by participants in consultation openings as a way for them to display their orientation to a particular activity or multiple activities, and when there are multiple activities or foci of their attention, the degree of focus on each activity, is also seen in this data.

Figure 19    Three-party mediator introductions: Embodied realization of participation frameworks: Multiple points of focus by doctor (C21)

Figure 19 shows how the doctor’s postural position demonstrates simultaneous points of focus, with the head and lower body oriented towards the patient (to whom he is introducing other members of the medical team) and upper body and arms oriented towards the medical team (who cannot be seen in this image, and who are being introduced to the patient).
Multiple foci of attention expressed by body orientation are evident during introductions and (less obviously/often) case presentations. This parallels what Robinson (1998) described in relation to the way body orientation helps sustain multiple points of focus during primary care consultations, and Schegloff (1998) found in relation to everyday interaction.

During introductions, when the leading doctor’s attention is oriented towards both patient and other doctors (the parties being introduced) simultaneously, this split attention is often shown in the way the leading doctor’s body is oriented. Frequently the doctor’s lower body marks the direction of primary focus, and is oriented towards the patient, while the upper body (the marker of relatively subsidiary focus) is oriented towards members of the medical team or others being introduced to the patient.

The case notes can be characterized as a physical representation of the patient (see §5.3.6 for a more detailed discussion of this issue). During or at the end of case presentations, doctors’ bodies are sometimes oriented towards the case notes while their upper bodies, commonly led by the shoulders, turn towards the patient, as is shown in Figure 20 above, in what can be seen as a display of attending to different but related aspects of the patient’s needs.

During introductions, the leading doctor (who is introducing the patient to other members of the medical team) routinely orients his or her body in such a way as to have the lower part of the body oriented towards the patient, thereby displaying a primary focus of attention towards the patient, while orienting the upper body towards the medical team, showing focus but a subsidiary focus towards them (Schegloff, 1998; Robinson, 1998). If the patient is sitting and the doctor standing, the doctor sometimes bends down towards the patient as part of the demonstration of attention to the patient while arching the upper body and turning the head towards the medical team.

Introductions are a distinctive part of the bedside consultation and they exemplify and accomplish tasks unique to this clinical setting, and their presence reflects unique
imperatives shaping interaction in this clinical context. Introductions contribute to the establishment of trust and alignment between participants in the consultation by overtly acknowledging the presence and importance of members of the medical team and the patient by providing the means to acquaint or reacquaint them. The way introductions are designed may also implicitly show additional contextual features of the interaction such as the relative location of participants in the organizational hierarchy and the inherent vulnerability of the (in-) patient.

5.3.5 Pleasantries/howareyou sequences

Howareyou sequences are practices that enable participants in an interaction to display to each other and to negotiate whether or not they are ready to move from opening preliminaries to the main business of the encounter, whether in an ordinary conversation or a medical consultation. As with other question sequences, the howareyou sequence can have either two or three parts. The sequence can comprise a first and second pair part alone, or there can be an additional sequence closing third part assessment.

The recipient of the howareyou inquiry can treat the inquiry as a pleasantry or ‘small talk’, or as a sincere inquiry about the recipient’s state of health or wellbeing. If the howareyou recipient treats the inquiry as a pleasantry then the response that displays this understanding is a neutral one such as ‘fine thanks.’ If the inquiry is treated as genuine then the response that displays this understanding is a more detailed and specific response referring to some aspect of the recipient’s state.

Howareyou inquiry sequences display inquiry recipients’ understanding of the progress of the consultation, of whether or not sufficient preliminaries have been completed for the medical work of the consultation to begin. If the howareyou recipient is unready to begin the medical work of the consultation, s/he can treat the inquiry as a ‘greeting substitute’ (Sacks, 1992), and respond in such a way as to be neutral, polite, unrevealing and final (e.g. “fine”, “good”, “very well” +/- “thank you”). A greeting substitute response does not invite further questions, and forms a sequence, often with a third part assessment from the inquirer (e.g. “good”, “great” etc.) that stands as a polite but not probing inquiry. This
kind of howareyou sequence is very common in opening segments of conversations in many settings, particularly when interaction between people who do not know each other very well is involved, or when the setting is institutional.

Pleasantries and howareyou sequences are important and versatile components of the bedside consultation in this study, and conducting these activities is part of how the consultation is opened. At the bedside, howareyou inquiries are usually initiated by the doctor, and are treated by patients as both as bona fides inquiries and greeting substitutes, and which response this inquiry receives depends on its sequential location in the consultation (Schegloff, 1986; Coupland et al., 1994; Robinson, 2014). This is not distinctive in terms of medical discourse except that at the bedside, howareyou sequences that act as greeting substitutes are canonical, whereas in other medical settings, they are more occasional (Robinson, 1998; 2006).

Howareyou sequences occur as greeting substitutes during the opening of most bedside consultation openings (unlike consultation openings in other settings) possibly displaying a distinctive feature of the opening of this kind of consultation. This may be the relatively greater complexity of these consultations in terms of the number of participants, and a correspondingly longer ‘settling in’ process, of which greeting substitutes are a default component.

Alternatively, it may be that the bedside consultation has a more ‘social’ character to it because the patient is temporarily resident in the hospital, and so the more ‘social’ practice of greeting substitutes is treated as normal and necessary before a switch to business is made from preliminaries. At this point, alignment of attention and purpose is achieved, and a relationship of sufficient mutual trust and confidence has been developed for medical business to be able to be discussed.

Howareyou sequences in a medical context, or in a social context where the people in conversation are intimates (eg family members or very close friends) are more likely to be treated as bona fides requests about the recipient’s health or state of wellbeing. Responses to howareyou inquiries treated as bona fides requests for information about the recipient’s wellbeing range from slightly more downgraded or upgraded neutral
responses (e.g., “not bad”, “quite good”, “pretty well”) to more extremely positive or negative (e.g., “terrible”, “really good”, “barely surviving”). Such responses are marked as not normal and invite further response.

A howareyou inquiry (in common with other kinds of inquiries) allows recipients to design their response in such a way as to display how they wish to be understood. At this point in a conversation, howareyou recipients signal their understanding of how far they have progressed in the consultation, and whether or not they are ready and willing to move on to the main business of the encounter.

Schegloff (1986) observes that the response elicited by howareyou inquiries depends on their sequential locations in conversations. In the context of a medical consultation, the howareyou inquiry can be taken as a polite inquiry or greeting substitute (Sacks, 1992; Coupland et al., 1994; Robinson, 2014 and others) or it can be taken as a request for information, a specifically medically relevant description of a presenting complaint or symptoms since the last visit (Heritage & Robinson, 2006; Coupland et al., 1994; Pillet-Shore, 2008).

Schegloff (1986)’s suggestion that a conversation cannot be properly launched until certain necessary preliminary actions have been satisfactorily performed has been shown to be relevant in institutional settings including the medical consultation (Robinson, 1998; 2014). The sequential location of howareyou inquiries is a marker of whether or not these preliminary actions are understood and responded to by recipients as having been satisfactorily completed. Consequently, depending on its location in the consultation opening, responses to howareyou inquiries show that the inquiry recipient (usually the patient) understands and accepts that it is (or is not) not yet time for the main business of the consultation to begin (and so responded to it as a greeting substitute or as an opening elicitor).

If the howareyou recipient understands and accepts that the necessary preliminaries have been completed, then their response projects that understanding and acceptance that it is time to begin discussing medical issues.
and consequently treats the howareyou inquiry as a bona fide request for information. If the howareyou inquiry recipient (usually the patient) treats the inquiry as a greeting substitute, they design their responses in such a way as to display the way they wanted ‘how they were’ to be understood (Coupland et al., 1994). The howareyou inquiry sequence is therefore a versatile interactional practice for participants to monitor each other’s understanding of how they are progressing through the consultation and to negotiate aspects of ‘who’ they ‘are’ to each other for this interaction.

At the bedside, howareyou inquiries are often treated as opening activities and ‘small talk’, and responded to as pleasantries, and they are sometimes treated as bona fides inquiries into how the patient is feeling now. An example of each of these situations is presented below, from C44 (Extract 25) and C39 (Extract 26) respectively. Each of these cases not only exemplifies how howareyou sequences can play out at the bedside, but also shows how the interactional environment of these activities often appears in this study data.

In the consultation examined in Extract 25 and Figure 20, and discussed below, the patient treats the doctor’s howareyou inquiry as a greeting substitute in an interactional environment that exemplifies a number of features that characterize openings in this study. These include a multi-bed ward, a noisy environment, and the clear, coordinated interplay of verbal and embodied resources in organizing and accomplishing the howareyou sequence within the broader interactional context of the opening.

The elderly patient in C44 occupies a bed in a four-bed ward. As the consultation gets underway and as it progresses, the sound of loud talking from adjoining spaces intrudes into the conversation, at times making it difficult to hear what is being said. The doctor, followed by the medical team, walks quickly into the consultation space, and begins greeting the patient using a relatively formal greeting (“morning”) and a formal address term (“Mr Blundy”) before he has arrived by the bedside (line 1), to which the patient responds. At this point, the doctor begins the howareyou sequence (line 3).
Extract 25  How are you sequence as greeting substitute (C44)

The patient treats the doctor’s how are you inquiry as a preliminary opening activity or greeting substitute. This is evident in his neutral, uninformative response (“good thank you”) that does not invite further inquiry from the doctor, both because of the blandness of the adjective ‘good’ and because it is followed by a sequence closing ‘thank you’ (line 4). The patient’s understanding of the doctor’s how are you as an opening preliminary activity is also displayed by the coordinated extension of his hand to the doctor to initiate a handshake, which is a traditional greeting gesture and is also an instance of the touching which (as mentioned above) is a possible opening action (although rare at the bedside).

The doctor displays his understanding of the patient’s treatment of the how are you sequence as a greeting substitute by his sequence closing third, part assessment “very good”.

1  D  Morning Mr Blundy ((D walks into space as far as bedside))
2  P  Good morning ((MG loud speaking in adjoining bed))
3  D  How are you today
4  P  Good thank you ((extends hand to shake hands with doctor))
5  D  Very good. ((shakes hand, MG))
6  (0.1) ((P withdraws hand and places it on his chest))
7  P  how’s your pain?
8  (0.2)
Following the doctor’s sequence closing third, there is a slight pause before the doctor launches the core section of the consultation with the opening elicitor “how’s your pain?” (line 7). The timing of the doctor’s launch of this opening elicitor exactly coincides with completion of the patient’s hand-shaking gesture, as the doctor’s business-initiating inquiry begins at the instant after the patient’s hand comes to rest on his chest, marking the completion of the gesture.

In summary, in this consultation, the patient’s greeting substitute response displays his understanding that at this point, he does not feel that sufficient preliminaries have been completed to be ready to begin the core medical work of the consultation, and that opening activities consequently continue to be relevant. Conversely, the doctor’s howareyou inquiry is treated as a way of gauging the patient’s readiness to begin ‘business.’ Combined with embodied greeting actions (smiling, gazing, shaking hands), the doctor produces the sequence-closing third part assessment, showing his understanding of the patient’s prior response before moving on to core business (line 7), in response to the patient’s embodied signal (line 6) that he is ready to do so.
Howareyou sequences do not always play out as opening activities, however, and patients sometimes treat howareyou inquiries as bona fides inquiries into the current state of their (the patient’s) health. Howareyou sequences in these situations thereby act as opening elicitors and consequently a combination of opening and core business activity. An example of a howareyou sequence that is treated as an opening elicitor is discussed in the following section. It involves an elderly patient accommodated in a single room, and it exemplifies interactional features that characterize many howareyou (and opening) sequences in the data including the coordinated interplay of verbal and embodied actions (including smiling, mutual gaze and strategic occupation of the consultation space).

In Extract 26 (C39), the patient’s embodied and verbal responses to the doctor’s howareyou inquiry display her orientation to the question as a bona fides inquiry into her current state of health, and so as a bridge to business. The doctor smiles broadly as she enters the consultation space, which is a single room, and uses a smiling voice to greet the patient, using a relatively formal greeting form and address term (“good morning Mrs Findley”, line 1). The patient gives an immediate and matching response to the doctor’s greeting (line 2).

**Extract 26  Howareyou sequence as bridge to business (C39)**

1    D Good morning Mrs Findley ((D smiles, MG, walks to end of bed))
2    P Good morning ((MG, smiles))
3    D How are you this morning? ((MG, opens file))
4    P (.).
5    A little ((grimaces, shakes head))
6    (.)
7    y’ you know
8    D (0.1) ((P replaces grimace with smile))
9    P Not well? ((smile fades, MG, walks to bedside))
10   P (0.1)
11   No I didn’t have a very good night

However, in response to the doctor’s first part howareyou inquiry, the patient’s response follows a brief pause, and when it begins, is hesitant and equivocal (“a little”, line 5), and it continues using embodied resources, with a facial grimace and a side-to-side head-shake that displays embodied attempts to convey the patient’s experience of discomfort or pain (Heath, 2002). After a further pause (line 6), the patient completes her response, which even upon completion
remains vague (“you know”, line 7). As she completes her vague assessment of how she is feeling, the patient replaces her grimace with a smile, seeming to display troubles resistance (Haakana, 2001; Beach & LeBaron, 2002; Jefferson, 2004; Zayts & Schnurr, 2011).

The doctor’s response to the patient’s vague response in line 7 displays an understanding that the patient is not treating her (the doctor’s) howareyou response as a preliminary opening pleasantry, but rather is ready and willing to begin the medical work of the consultation. At this point (line 9) this understanding by the doctor is marked by a fading of the smile on her (the doctor’s) face, and her shifting position within the consultation space from standing by the end of the bed, facing the patient (lines 1-8), to standing by the bed next to the patient (line 9), from where her subsequent questioning takes place. This is shown in Figure 21 below where the mutual gaze can be seen as being maintained between doctor and patient as the doctor moves from the end of the patient’s bed to a closer location next to the bed in response to the patient’s treatment of the howareyou inquiry as a question about how she (the patient) is feeling now.

The doctor’s response at line 9 follows a relatively long pause, which the patient fails to fill with further elaboration. When the doctor’s response comes it was is circumspect, framed as a declarative question seeking confirmation for a candidate interpretation of the patient’s comments in lines 5 and 7: “not well?”.
5.3.6 Case presentations

The activity of case presentation is a regular component of the bedside consultation opening that participants do not treat as essential, but which is unique to this setting. Several types of case presentation are evident in this data, and they are described in this section. The case presentation plays an important part in the education and professional socialization of junior doctors at the bedside.

The case presentation may be carried out away from the bedside, in a conference room at the hospital, however at the bedside, it is part of the teaching work of the consultation, where a doctor presents a summary of the patient’s medical situation (including medical history, diagnosis, tests and treatments to date) to the rest of the medical team.

The medical case study is a long-established medical practice that has traditionally provided data points in efforts to find and categorize patterns in the incidence and manifestation of disease (Lang, Damousi & Lewis, 2017). However, in addition to this, it has a powerful role in framing the way clinical and other medical concepts are talked about, and it has thereby played an important role in “setting the discipline’s professional discourse” (Lang et al., 2017: 8). As such, the case presentation is an important means of providing professional socialization for junior doctors, as well as for reinforcing professional norms for more experienced practitioners.
The language of the case presentation has been described as being framed in language that distances the presenter from responsibility for the information and decisions contained in the presentation, that creates emotional distance between presenter and patient in a way that runs counter to principles of empathy, care and responsibility which may be implicitly and explicitly promoted as part of the ethical framework of medical practice (Anspach, 1988). Four distinguishing characteristics of the language of the case presentation that Anspach suggests frames the discourse in this way are as follows. First, *depersonalized language* (by decoupling reference to the patient as a person from reference to the diseases or other physical processes affecting them). Second, *omission of an agent in accounts of the patient history* (resulting from use of the passive voice, which has the effect of distancing the speaker from responsibility for information contained in the utterance). Third, *treatment of “…medical technology as agent…”* (p. 357; by using the active voice when reporting actions performed by machines e.g. tests, imaging procedures), and finally, [the] *use of account markers* when recounting information given by the patient (implying that the information given by the patient may not be reliable) is a recurrent feature of the language of case presentation.

Case presentations in this study, however, seem to be framed in less distancing ways than Anspach (1988) reported, with less use of the passive voice when referring to the patient’s history as well as to procedures and tests performed, and the use of personal pronouns when referring to members of the medical team having ordered actions or tests or other treatment, thus interactionally accepting responsibility for such actions and creating a link of care of and empathy towards the patient that Anspach reported to be missing in his (now thirty-year-old) data. Examples of these ways of constructing a case presentation can be seen below in Extract 27, which is discussed in §5.3.6.1 below. The doctor also softens the fact she is talking about the patient in her presence by looking and smiling at the patient periodically.

In a clinical setting the case study is verbally presented by a clinician to audience of other clinicians. In this way, the construction and presentation of the medical case study has been and continues to be an important tool of professional socialization as
well as clinical training for trainee doctors, conveying aspects of medical practice described by Hafferty & Franks (1994) as “the hidden curriculum”. As an educational activity, the case presentation may be conducted in the presence of, or away from the patient.

Because the case study is a summarized account of what the presenter selects as being medically relevant features of the patient’s circumstances, the patient’s direct input is not needed for its presentation, and this is the reason that the presentation need not occur in the patient’s presence (and often doesn’t). Indeed, in the hospital setting, the case presentation often occurs in a separate room, sometimes on a weekly basis, in the presence of a medical team or others involved in patient care. At the bedside, the patient is present when case presentations are given.

The case presentation generally has a narrative structure where the presentation is delivered as an extended turn at talk with the audience waiving its right to take a next turn at successive TCUs (Lang et al., 2017).

Although the case presentation is an activity unique to the inpatient bedside setting and not relevant in other kinds of medical consultations, the case presentation is not treated as relevant in every consultation.

There are two dimensions within which the occurrence of the case presentation varies: the type of consultation during which it occurs and the location within the consultation it occurs. Table 5-4 below shows where and when the case presentation occurs at the bedside.

Table 5-4  Sequential location of the case presentation in different consultation types

<table>
<thead>
<tr>
<th>Consultation type</th>
<th>Case presentation during opening (%)</th>
<th>Case presentation during core (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regular (n = 31)</td>
<td>75</td>
<td>25</td>
</tr>
<tr>
<td>Changeover (n = 17)</td>
<td>17</td>
<td>83</td>
</tr>
<tr>
<td>All (n = 48)</td>
<td>40</td>
<td>60</td>
</tr>
</tbody>
</table>
Overall, case presentations occur during 18% (n = 9) of consultations in this study. Half the case presentations that do occur, occur during regular consultations and half during changeovers. However, because there are fewer changeover consultations than regular consultations, changeovers are proportionally more likely to contain case presentations: 24% of changeovers have case presentations whereas only 13% of regular consultations do.

Case presentations occur only rarely in consultation openings: 9% of openings (n = 4) contain a case presentation. When case presentations occur during openings, this always occurs during a regular consultation, so the case presentation is treated as an opening activity. When case presentations occur during the consultation core, they are treated as part of the core business of the consultation, something that is proportionally more likely to happen during a changeover consultation.

The distribution of these case presentations between regular consultations and changeover consultations is 50/50. That is, half the case presentations occur during regular consultations, and half occur during changeover consultations. Some case presentations occur during the main or core of the consultation (n = 3), making the total percentage of bedside consultations containing a case presentation at some stage 15% (n = 7). This activity is however unique to bedside consultations compared with consultations in other settings and is therefore a particular focus of attention in this study.

Participants in the bedside consultation orient to case presentations as being relevant to the educational function of the consultation. This educational dimension is oriented to as coexisting with the consultation’s clinical patient care function and is expressed in a number of structural and interactional ways. In addition, the bedside consultation is supervised clinical training and education for medical students that traditionally occurs as part of the bedside round. The case presentation also presents an opportunity for professional socialization for junior doctors.

Participants in the bedside consultation orient to three different types of case presentation, which are governed by correspondingly different norms regarding (1)
rights to the floor, (2) rights to question or challenge the speaker and (3) rights to give explanations to the patient. All three types of case presentation occur in the presence of the patient. However, their forms vary as does the work they do. I have called these different categories the ‘demonstration’ case presentation, the ‘candidate’ case presentation and the ‘peer’ case presentation. Examples of each kind of presentation are discussed in §5.3.6.1 (‘demonstration’), §5.3.6.2 (‘candidate’) and §5.3.6.3 (‘peer’) below.

‘Demonstration’ presentations are conducted by senior doctors to the rest of the medical team and are treated as a model of how a case presentation should be *constructed* and *presented*. In this way, the ‘demonstration’ case presentation acts as a teaching activity, where a senior doctor presents the case and the rest of the team listens and watches. The fact that this kind of consultation is treated as a modeling activity motivated the choice of ‘demonstration’ as its label.

Junior doctors conduct ‘candidate’ presentations to an audience of the medical team, led by a supervising senior doctor and the patient (and any family members present). These presentations are treated as an opportunity for junior doctors to attempt to devise and present a summary of the relevant details of a patient’s ‘case’ to the rest of the medical team under the supervision of the senior doctor. The doctor can be seen to be modeling the organization of the case on the ‘ideal’ model evident in ‘demonstration’ presentations (such as discussed in §5.3.6.1, Extract 27). Two examples of ‘candidate’ presentations are discussed in §5.3.6.2, Extracts 28 and 29 below.

The final category of case presentation is what I have called the ‘peer’ presentation, where a (probably senior) doctor informally presents the case in an abbreviated form to a fellow (senior) doctor (a professional peer), possibly in a ‘backstage’ manner, that is, quietly, in parallel with the consultation that was being conducted simultaneously by another doctor. This kind of presentation was rare in this data, and an example is presented and discussed in §5.3.6.3, Extract 30. Because this study aims to show how the bedside consultation is *or can be* conducted, unusual as well as more usual forms of activities are acknowledged in the account. This is also consistent with the respect
CA theory gives to the outlier, the aberrant example, as a source of insight into a
different aspect of an activity or encounter.

5.3.6.1 The ‘demonstration’ case presentation

An example of the ‘demonstration’ presentation, where a senior physician delivers a
case presentation to the medical team that is treated as a model of how case
presentations should be delivered (C24) is shown below (Extract 27). In this way, the
demonstration case presentation is an important clinical training resource in
medical education, in which junior doctors are socialized into how to behave or do the
work of being doctors and also (although it is beyond the scope of this thesis to
investigate the consultation intensively from this theoretical perspective) as a means of
professional socialization of junior doctors and medical students.

In the demonstration case presentation, the senior doctor shows juniors how the case
presentation is optimally constructed, meaning how medical and clinical knowledge is
conceptualized, articulated and ordered, as well as how it is talked about
and reported to other medical staff in a standard clinical format. Because the
demonstration bedside case presentation represents a ‘standard’ against which less
experienced attempts at case presentation can be measured, it is the type of
presentation we examine first.

The consultation in this example occurs in a private room, with a medical team of
five present in addition to the leading (senior) doctor, in a changeover
consultation. The patient is an elderly woman, and no family members are present.

Extract 27 Demonstration case presentation (C24)

1    D    Now how are you Mrs Miller came to us from the country
2    (0.1)((steps back, changes position to face team, looks at
3        team))
4    D1   Uh hum
5    D    With abdominal pain
6    D1   Uh huh
7    D    (.)(steps back, facing team, looks at D1))
8    D    So she had severe abdominal pain ((hands to abdomen))
9    (.)
10   D    seemed to be worse ((hand gesture)) when eating ((looks at
11        team))
12   (.)
better lying down ((turns to look at P))
(0.1)
ahhm associated with some constipation ((nods, looks at D1))
(.)(((turns to look down at notes on P bed))
s o((looks at P)) we brought her down here she has a
past history ((looks at D1, folds arms)) of um peripheral
vascular disease
(.)
she’s got a Gore-Tex graft ((looks at P, MG)) across her groin
(.)
from side to side ((2 handed iconic gesture, looks at D1))
(.
ah she’s got uh ((looks at P))
(.)
an abdominal aortic aneurysm ((looks at D1, clasps hands)) of
five point five three centimetres
(.
has had ((frowns, looks into distance)) ischemic heart
disease ((beat, 2 hands))
(.)
she’s got cerebro-vascular disease
(.)

P ( ) ((Heh heh)) ((smiles, MG with D who smiles in response))
D Hhh so ((looks at P)) we were wondering if she had ((looks at
P, MG, smiles)) mesenteric ((looks at D1)) ischemia
mesenteric angina
(.(turns back to look at P))
so she had an abdominal ultrasound before which showed ((looks
at D1)) heavy calcification ((2 hand gesture)) in the celiac
axis ((beat gesture)) SMA ((beat gesture))
(.
and the aneurism ((nods, beat gesture)) and the IMA’s not
visible ((beat gesture, looks at P))
(.
but no ((looks at P)) haemodynamic((looks at D1)) lesion
(.
so:: ((looks at P)) yesterday we organized a colonoscopy
((nods, MG)) and do you know what the results ((nods) of the
colonoscopy were? ((nod, MG))

The case presentation begins after a false start, where the senior doctor initiates a
howareyou sequence flagged by the transition or discontinuity marker “now” (line
1: “now how are you”) (Bolden, 2014). However immediately after the
howareyou inquiry, the doctor changes direction and in an action of self-repair, instead
launches the case presentation with: “Mrs Millar came to us from the
country” (line 1).
The case presentation has a narrative-like structure consisting of an extended turn at talk where the presenter occupies the speaking floor for the duration of the presentation, and recipients (the medical team) play the collective role of the audience. This presentation is narrative-like in the sense that the presenter (like the teller or narrator of a story) uses it to relate a multi-part story packaged in an extended turn (Mandelbaum, 2014 for a review of story-telling literature; Labov & Waletsky, 1967). Listeners treat the presentation as a narrative or story with incremental additions of new relevant sequential information by declining to take up successive possible next turns at successive possible TCUs during the presentation (telling) or nodding at these points by way of signaling engagement and alignment (Stivers, 2008).

The presentation is organized with an initial introductory phase where the senior doctor introduces the patient (line 1) and summarizes her presenting symptom (line 5). Another senior doctor in the team (D1) acknowledges displays an understanding that an extended turn is underway that is not yet finished (Schegloff, 1982) with the continuer “uh mm” (lines 4 and 6) after each piece of introductory information (the patient’s name and her presenting symptom), displaying the second doctor’s understanding that a narrative is being introduced, and permitting, if not encouraging the presenter to continue.

Thereafter, the presenting doctor and the team work together to allow the presenter to hold the floor over an extended series of turns, with the team repeatedly foregoing opportunities to take the floor at points of possible speaker change. The presenting doctor’s extended turn continues until she signals a transition into the next activity at line 43 using the procedural discourse marker “so:” (Fraser, 1999; Bolden, 2014) that marks the next activity as relevant to institutional goals and a medical agenda, and this is followed mid-turn with the discourse marker ‘and’.

The only interruption to the presenter’s hold on the floor is when the patient laughs in response to the doctor’s recitation of the (many) medical symptoms and issues relevant to the patient’s current hospital admission (line 38). The presenting doctor treats this action of the patient’s as expressing discomfort or embarrassment (Haakana, 2001;
Jefferson, 2004) by responding with mutual gaze and an affiliatory smile to the patient (line 40).

The content of the case presentation narrative consists of a systematic recounting of the patient’s symptoms (lines 5–18), past medical history (lines 21–36), candidate diagnosis (line 40–41), tests performed (line 43) and test results (line 44 and 47) and further tests ordered (line 52). The systematic progression through this collection of pieces of information has a checklist ‘feel’ to it.

At line 52, the discourse marker and conjunction “and” follows the procedural marker “so::” to launch the next activity, a patient feedback request (lines 53-54): “do you know what the results of the colonoscopy were?”

Despite (and perhaps because of) the checklist appearance of the transcript and of the content of the case study, to present it, the doctor relies heavily on embodied resources (including coordinated gaze, gesture and body orientation and movement) to define a dynamic participation framework and involve other participants (even – perhaps especially - if their roles are as observers of the presentation).

Embodied action is a multifaceted set of communicative resources that doctors, patients and others deploy throughout the consultation in many ways. Because of the complexity of ways these parties intertwine embodied and spoken action, in describing what goes on at the bedside it has been necessary in this thesis to focus on a limited range of these practices throughout the discussion. In Figures 22, 23 and 24 (C24), the doctor’s use of hand gesture, body orientation, head movement and gaze are important in conducting the case presentation, and I focus on this aspect of what she does to accomplish this work in the discussion that is illustrated in Figures 22–24 below.

The presenting doctor deploys gesture to convey the location of symptoms (Koschmann et al 2007) and nature of issues such as previous treatments or responses which when described verbally sometimes has potentially impenetrable technical descriptions (lines 24 and 26: “she’s got a Gore-Tex graft across her
“groin/from side to side” – see Figure 22 below). The orientation of the doctor’s body while she was articulating this information was such that the action was displayed as being for the benefit of the patient as well as members of the medical team.

Figure 22  Deploying gesture describing past procedures during case presentation (C24)

The presenter also deploys beat gestures to depict checking off items when listing previous maladies in the patient’s medical history (lines 21-36, see Figure 23 below).

Figure 23  Deploying gesture to outline patient history (C24)

The presenting doctor also coordinates gaze and body orientation to show multiple simultaneous points of engagement (as shown in Figure 24 below) as a means of
maintaining inclusion and involvement of all participants in a multiparty interaction. Figure 24 shows how the presenting doctor aligns her body towards the patient, hence engaging with her (the patient, in the bed) while at the same time twisting her body and gaze around to the medical team as she begins the case presentation, introducing the patient: “now Mrs Millar came to us from the country” (line 1). At this point other team members look at the leading doctor, and although mutual gaze is not always established, all team members look at the presenter as she speaks, and she shifts her gaze around the group.

The presenting doctor uses gaze to engage different participants during the case presentation and also as a resource to delineate or parse sequences within the telling. Rossano (2012, 2014) found that speakers in extended tellings withdrew their gaze at the end of sequences, but during this case presentation, the presenting doctor looks at the team (usually D1 in particular) after she has outlined a key aspect of the patient’s history, responses since admission (“we brought her down here” line 20), diagnosis (line 36), candidate diagnosis (lines 40-41) and most recent tests and results (line 44-45, 47).

The presenter also looks at the patient throughout the presentation, but these glances often follow points of interactional transition between items on the list of symptoms, actions, diagnoses and tests rather than after key items as is the case with the other
doctors. This pattern of looking displays acknowledgment of the patient and acts to include her but also possibly to signal an orientation to the relevant recipients of information discussed. That is, members of the medical team are the clinically relevant recipients of the information conveyed in the case presentation, but the patient is the subject of the case, which at least indirectly includes her voice (Lang et al., 2017). Therefore, the patient is also a relevant recipient for the information in the case, independently of the fact that she is present during the telling, and the doctor’s gaze pattern shows an orientation to the relevance of including her, but at less clinically important points.

The patient is physically present during the case presentation, but she is also present during the case presentation in different and more abstract ways. The medical case study is a way of representing a person in such a way as to reduce him or her to a set of medically related features which link the patient to the author/s and audience (when the study is presented) of the case study. Lang et al describe its traditional purpose as being “a means of conveying and containing medical knowledge about patients” (Lang et al., 2017:9). In this way, then, the patient is present during the case presentation not only in person, lying in her bed, but also in the presentation of her case given by the senior doctor.

In addition to this, the patient can also be seen to be present in a similarly abstract, disembodied form in patient records used at the bedside consultation in the trolley-borne computer records. Members of the medical team can be seen to orient to the patient in this disembodied form in Figure 25 below.
5.3.6.2 The ‘candidate’ case presentation

A second type of case presentation occurs when a junior doctor presents a case history of the patient to the medical team, including his or her supervisor/s. This is treated as an opportunity for the student or junior doctor to display his or her grasp of the clinical skills and thinking required to work as an independent hospital physician, and for the supervising senior doctor to prompt, challenge and test the junior’s mastery of these skills by relevant questioning and feedback (Extract 28 (C20).

Two examples of candidate case presentations are discussed in this section, to illustrate contrasting interactional styles in these presentations in this data, and to show how the manner of the supervisor seems to influence the interactional character of the presentation. Despite differing styles of different doctors, participants in candidate case presentations orient to a similar organizational structure, which is distinct from that of the demonstration presentation. Whereas the demonstration presentation is organized as an extended narrative, during which the presenter holds the floor and onlookers periodically silently signal their engagement by orienting their bodies towards and gazing at the presenter, participants in candidate presentations orient to different distribution rights to the floor.
In Extract 28 (below, C20), a junior doctor (JD) and senior doctor (SD) stand side by side, by the patient’s bed in a six-bed ward. The patient is an elderly man, no family members are present, and the consultation is a changeover consultation.

Extract 28    Candidate case presentation (C20)

1 JD Dr Ross as you know ((JD turns to SD, smiles; SD turns towards JD, looks at patient notes))
2 JD (0.1)(JD looks at notes))
3 SD Yep
4 JD (0.1) ((SD turns and leans down towards, looks at P))
5 Eighty ninety-five-year-old man ((SD steps back, crosses arms, looks at notes; JD looks at notes))
6 (.) ((SD turns to look at P))
7 posterior? ((JD looks at SD, SD looks at notes))
8 (.)
9 circulation,
10 CVA ((JD looks at notes))
11 (0.3)((JD looks at and turns pages of notes))
12 SD Okay ((steps back))
13 JD (0.1) ((JD continues to turn pages of notes, smiles))
14 ( )((SD steps back and closer to read notes))
15 Suggest that the (pittigrule)
16 (.)
17 and we’re waiting for a carotid referral to (sense)((looks at SD))
18 (0.1)((SD and JD both turn to look at P, smile))
19 SD Hi ((MG, smiles))
20 P You’d think it was Paul Hogan wouldn’t you? ((looking and pointing at camera))
21 SD I know I know

There is moderately loud, constant and intrusive background noise throughout this presentation. In addition, the junior doctor who presents the case speaks in a soft voice that is difficult for the patient to hear. However, for most of the presentation, the orientation of the presenting doctor’s and his supervisor’s bodies and gaze exclude the patient in their focus, as can be seen in Figure 26 below. Instead, both doctors display a focus on the ‘disembodied patient’ in the form of the patient notes, except for a single point (line 5), when the senior doctor turns, bends his body and redirects his gaze towards the patient. Thereafter, the senior doctor’s bodily and gaze orientation returns to the notes. The first and third images in Figure 26 coincide with lines 1 and 4 (“Dr Ross as you know”/”yep”) and show the senior doctor’s arms by his sides in what may indicate a state of readiness or transition.
These observations highlight the importance of embodied resources in case presentations in displaying shifts in the focus of participants’ attention, and also in defining and redefining the framework of participation (Goffman, 1981; Ruusuvuori, 2001; Robinson, 2001). As with the senior doctor in the demonstration presentation discussed above, the junior doctor looks at the senior doctor after he begins a new course of action within the presentation, orienting to the use of gaze as a means of parsing activities and marking the introduction of an activity. For example, at line 1 he begins the case presentation (marked by his introduction of the senior doctor (“Dr Ross as you know”), whereas at line 9, he begins to recount the patient’s relevant history (“posterior [... circulation ... CVA”]) and at line 20, he
reports what the current actions are (“and we’re waiting for a carotid referral to ( )”).

When the senior doctor in C24 uses gaze to mark the introduction of new phases of the case presentation, gaze recipients treat these actions as ‘signposts’ in the consultation and acts of inclusion and acknowledgment (recipients of the senior doctor’s gaze at these points silently meet her gaze and/or smile in response). However, in this presentation, the junior doctor’s looking at the senior at these points of transition are treated more as embodied requests for reassurance. At line 2, although the senior doctor (whose arms were tightly crossed throughout the presentation except when acknowledging the patient at line 8) turns towards the junior at this point, he neither establishes mutual gaze with the junior nor smiles in response to his smile, but rather looks at the notes. After a pause during which the junior was reading the notes, the senior gives a brief verbal acknowledgment (“yep” in line 4).

Again, at line 15, after the junior doctor has haltingly outlined the current diagnosis and during a long pause at line 14 is leafing through the patient notes, the senior doctor steps back and, still looking at the notes, signals approval or acceptance of the summary (“okay”). Finally, after the junior presenter reports the current status of the case at line 18, the senior doctor treats the falling tone used by the junior at the end of the summary as a cue to initiate a move to the core business of the consultation. In doing so, the senior gives the junior no overt encouragement but only minimal approval. Throughout the presentation there is no mutual gaze exchanged between the senior and junior doctors, as mentioned before, the junior’s smile to the senior is not returned (although it may also not have been seen since no mutual gaze was established), and the senior doctor maintains a closed body position throughout the junior’s presentation. Although all these actions of the senior doctor appear to convey distance, they show intense focus and engagement and it is possible that in this context this can be taken as encouragement. However, the junior doctor’s apparent reticence (quiet voice, hesitancy, leafing through patient notes, looking to the supervisor for approval) convey uncertainty and lack of confidence.
At the end of the presentation, the senior doctor takes over the role of the consultation leader, and within seconds has relaxed his body, which he turns towards the patient, establishes mutual gaze with and smiles at the patient and assumes a smiling voice and friendly tone in his discussions. This contrast marks the candidate case presentation as a distinctive and distinct, if brief, component of the opening, and a distinctive type of case presentation.

This presentation has the broad narrative structure of the demonstration presentation, but the presenter orients to having a weaker claim to the floor, and the senior supervisor orients to having a stronger claim to the floor than members of the medical team in the demonstration consultation (Extract 27 (C24). It is possible that these orientations to the distribution of participants’ rights to the floor expresses the institutional relationship between the senior and junior doctors, where guidance and approval are expected, sought and given between the two doctors, as well as correction where needed (for example at the point where the senior turns to acknowledge the patient at line 5 when the junior fails to do so).

Extract 29  Candidate case presentation (C16)

The consultation where this case presentation takes place occurs in a single room and involves a middle-aged patient with no family members present. It is a regular (non-changeover) consultation involving a medical team with five members). A junior doctor (JD) delivers the case presentation to a senior doctor (SD), and at a point midway through the presentation when the junior presenting doctor leaves the space (line 11), another junior doctor (JD1) takes over the presentation (line 13):

```plaintext
[missing section]
1  JD  And uh hospital in the home
2     (.)
3       are looking at
4     (.)
5       potentially tomorrow
6     (.)
7       if he if he if his if his pain’s controlled ((SD nods)) but it
8       isn’t controlled ( ) and what we’ve done is increased the ( )
9     and added some ( )
10  SD  And the ultrasound? ((puts folder on chair, looks at JD))
11  JD  Oh I’ll just go and show you
12     (.)((JD leaves consultation space to get ultrasound images))
13  JD1  He’s on uh I think four hourly (or gid) fluclox as well as
cettriaxone () ((SD looks at JD1, nods repeatedly, JD1
```
metaphoric hand gesture))
SD He’ll need a picc
(.)(nods repeatedly, looks up to establish MG with JD1, raises
eyebrows))
JD1 How quickly can they establish a picc line?
SD Pretty quickly ((MG, smiles))
(.)(turns to look at P and establish MG with him)
we’re just saying that the for antibiotics
(.)
to go home
(0.2)
you can’t have sort of
(.)
drips put in
(.)
every couple of days at home
(.)
so they have a big drip that goes in your elbow
(.)
uh
(.)
and that can stay in for
(.)
weeks

In this consultation, participants orient to a similar distribution of rights to the floor
as are evident in Extract 28 (C20) above, with the supervising doctor taking the floor
from the junior presenter to ask a prompting question at line 10 (“and the
ultrasound”). In response the junior presenter (JD) orients to this as being a
relevant prompt, and at line 111 produces an offer (prefaced by the discontinuity
marker “oh”) to retrieve and show the senior doctor the ultrasound images. She then
leaves the space to do this, and the SD turns to watch her leave, then turns back to
JD1.

After JD leaves to fetch the ultrasound image her colleague, JD1 takes over her role as
case presenter. After his resumption of the presentation, reporting the patient’s current
medication regime (at line 13), the senior doctor again interjects with an implied
directive (line 16) “he’ll need a picc”. Unlike in Extract 28, Figure 27
(C20) – the previous example - the senior doctor establishes mutual gaze with the
junior at this point, and nods, prompting the junior to ask for clarification (line
19: “how quickly can they establish a picc line?”), which the
senior immediately supplied at line 20: “pretty quickly”. 250
At this point (line 22) the senior doctor takes the floor to explain to the patient what has been under discussion in the presentation. This case presentation is included in the discussion of candidate presentations because it provides a contrast to C20 in terms of the atmosphere of the interaction and the effect that the actions of the supervisor have on the responses of the juniors within the constraints of a similar set of orientations by participants to the distribution of rights to the floor, and rights to intervene.

Figure 27 below shows how the members of the team occupy the consultation space and position their bodies and gaze direction in relation to each other. In Figure 27 (C16), the supervisor stands next to the patient’s bed, holding his body in an open position with the patient notes in one hand and holding onto the edge of the bed with the other. He gazes either at the patient (while JD, to his right, in a red cardigan) is speaking, or at the junior presenting doctor (JD1, standing on the opposite side of the bed, facing the senior) is speaking.

The senior doctor periodically establishes mutual gaze with the juniors and looks at them while they are speaking (lines 13-19), as well as acknowledging their contributions with frequent nods in response to the contents of their turns (lines 11,13,19). He also asks prompting questions and accompanies his response (line 20) to JD1’s request for clarification in line 19, with a smile. Following that, the supervisor takes the floor (as in C20), but to provide a link between the presentation discussions and the patient by explaining what had been discussed using technical
language (lines 20-38). In so doing, the senior doctor not only acknowledges the patient and the possibility he may not have understood the discussions during the presentation, but also validates the contribution of the juniors to the team, by prefacing his explanation with (line 22) “we”.

5.3.6.3 The ‘peer’ case presentation

A third category of case presentation was rare and occurred when senior doctors summarize the details of patients’ ‘case’ to peers (C48, Extract 30) Examining this kind of presentation offers the opportunity to identify differences between the way doctors talk to each other about a patient’s medical history and presenting symptoms and how these issues are talked about in the more formal and public forum of the ‘official’ case presentation (as discussed in relation to C24 above). Differences emerging from such a comparison highlight the distinctive register of the ‘officially sanctioned’ case presentation provided as an example to learners. This ‘official’ register encapsulates institutionally approved ways of summarizing the combination of “editing, omitting and evaluating” (Lang et al., 2017:9) what patients have told their doctors, and what doctors have observed about the patient’s symptoms, progress and condition, and information about this that testing has revealed.

In this case, the consultation where the (peer) case presentation in Extract 30 below takes place occurs in a shared four-bed ward, during a regular (non-changeover) consultation, where the patient is a middle-aged woman. No family members are present. The ambient noise during this exchange is sufficiently loud as to render parts of the conversation unintelligible, and consequently the account of the presentation is based on somewhat incomplete data. Despite this, a discussion of this distinctive variety of case presentation is included in this study because by showing this variation it helps illustrate the complex variety of relationships and lines of communication that characterize the bedside consultation.

This kind of case presentation illustrates not only the multiparty nature of the bedside consultation (because it occurs within the context of an ongoing consultation involving the medical team of which they are members) but also the various hierarchical relationships that exist between participants. These relationships influence the way
participants at different levels of the hierarchy and with different roles speak to each other, the kinds of information they seek and exchange and the way they talk about this information. Extract 30 shows that participants in this peer presentation orient to different rules regarding rights to the floor than can be seen shaping interaction in demonstration and candidate case presentations. In both these other types of consultation, participants orient to the current speaker (in demonstration presentations, the senior doctor, in candidate presentations, either senior or junior doctor) having the right to the speaking floor. In this ‘backstage’ presentation, participants orient to an interaction order where there are parallel floors, one held by the ‘official’ case presenter, and another available to members of the medical team who are more senior than the current presenter (if they happen to be junior, as in this case).

The overall structural organization of this consultation Extract 30 (C48) is discussed in detail in Chapter 4. This peer presentation was treated by the participants as fulfilling the purpose of ‘filling in gaps’ in the presentation recipient’s knowledge about the case with which the presenting doctor displays himself as being more fully informed about than the recipient.

**Extract 30  Peer case presentation (C48)**

1 D She had a really nasty cellulitis
2 D1 (.
3 see the original mar::kers?
4 D1 Yeah
5 D (.
6 which antibiotics? ( )
7 D ( )
8 D1 Say again
9 D1 kreflex?
10 D [(She had Keflex) the last batch had more sensitive staph]
11 D1 [Do they go under (        ) alright?]  
12 do they go under

This presentation is brief, less comprehensive than other kinds of case presentation, and interrupted by intrusive ambient noise. The transfer of information between the two senior doctors, who are peers in the institutional/professional medical hierarchy, is more informal in tone than the public presentations such as in C24 (Extract 27), or than the presentations between participants with an asymmetrical relationship in terms of professional authority and experience, such as in C16 (Extract
29) and C20 (Extract 28). The brevity of the presentation displays the understanding negotiated by the two doctors of what pieces of information are most important to know about the patient’s condition. This information consists of the diagnosis (line 1), its severity (lines 1, 3 and 10) and how it has been treated (lines 5, 7 and 10).

Structurally, the presentation is organized as a dialogue involving a series of adjacency pairs, largely question sequences, rather than as an extended narrative like the demonstration presentation in Extract 27 (C24), or a combination of extended narrative interrupted by questions, as in candidate presentations such as Extract 29 (C16). The presenting doctor reports the diagnosis of the patient’s malady: “she had …Cellulitis” (line 1), referring to the patient not by name but as “she”. A distinguishing feature of this presentation compared with the other more public forms of the presentation is the inclusion by the presenter of an evaluation of the severity of the condition, using an un-technical description: “really nasty” (line 1).

The information conveyed by the presenter to his colleague consists of the patient’s diagnosis, an evaluation of the seriousness of the condition, the medication prescribed to the patient, and why. As mentioned above, the patient’s medical history is omitted from this presentation and questioning, as is talk about plans for management of the patient from now on. The omission of these pieces of information can be explained by the fact that these doctors had arrived sufficiently early in the consultation core to have heard some of the ‘official’ case presentation and discussion of next steps. In addition, importantly, the peer presenter is supervisor of the junior doctor who gives the main (‘official’) case presentation during this consultation (C48, see full transcript in Appendix 6). His prior knowledge of this patient’s case is evident in his declarative question at line 3 “see the original markers?”
The (senior) doctors who participate in this peer case presentation stand next to each other, as shown in Figure 28 above (they are the two men at the right of the medical team, standing by the end of the patient’s bed. Their body orientation is towards the main presentation and their stance is relaxed. They speak softly despite the ambient noise of the room and the competition of the ‘official’ presentation.

5.4 Summary

The aim of this research is to describe the bedside consultation with reference to data in this study, and to help achieve this, the research question shaping this chapter was:

RQ2 How is the bedside consultation opened?

This question was addressed by outlining the overall structural organization of the bedside consultation opening as a whole (§5.3), and subsequently describing activities observed in openings in this data with reference to this framework. These activities are the means by which participants come together physically, synchronize their attention, align their perspectives and (re-) establish their relationships to each other for the purposes of the bedside consultation and by describing how these activities were organized in the consultation opening in this study. The conduct of the activities of the consultation opening was also described in such a way as to capture variation that may
characterize or be evident in them, as well as to show how participants oriented to apparently distinctive issues and dilemmas not described in relation to other types of medical consultation.

Although the consultation opening was almost invariably very brief (§5.2.1), a great deal of interactional work was accomplished at this point that was consequential and foundational for the remainder of the consultation. The importance of the opening in interactions of all kinds has been demonstrated in the large body of research devoted to the subject (Pilet-Shore, 2008; Robinson, 1998, 1999; Schegloff, 1968).

In this chapter, questions about how doctors and patients work together to open bedside consultations were addressed. I outlined activities that characterize the consultation opening or are apparently unique to this setting or are realized in a distinctive way at the bedside compared with accounts of consultation openings in other clinical settings. Consultation openings in this data could contain the following activities: becoming co-present, greetings, registering/settling in, introductions, howareyous, and case presentations.

Activities distinctive to the inpatient bedside setting included introductions and case presentations (although these were sometimes treated as part of the consultation business and consequently occur during the business section of the consultation rather than the opening, as discussed in Chapter 4). I explained how these two activities co-occurred during the consultations in this study and suggested that they possibly form some kind of introductory composite activity unique to the inpatient bedside consultation. Both of these activities also displayed the impact of the multi-party and multi-purpose character of this kind of consultation which also seemed to set the bedside consultation (at least in this study) apart from consultations in other settings.

Case presentations also highlighted the multipurpose nature of the bedside consultation in this study, where the work of the consultation included education and professional socialisation of junior doctors as well as patient care.
The distinctiveness of the inpatient setting also seemed evident in activities seldom described in relation to other medical consultation types, such as settling in and registering. Included in these activities offers of hospitality were sometimes evident, but in the opposite order to that found in other clinical settings – the patient offered the doctor hospitality rather than vice versa. The organization and conduct of these sequences apparently highlighted distinctive tensions and dilemmas directly associated with this setting.

Offers of hospitality during activities are occasionally found in consultations in other clinical settings where the doctor offers the patient a seat after the patient enters the consultation room sometimes occurred in this data. However, in this study, the dynamics were reversed at several levels: at the bedside, the medical team entered the space around the bedside, leaving the patient in a position of offering hospitality. This also highlighted ambiguity over ‘ownership’ of the consultation space in a way that seemed unique to the inpatient setting.

The opening is a time when participants in an interaction activate their identities and relationships to each other and mark out the associated rights and responsibilities for this occasion. Both doctors and patients in this study oriented to the encounter having begun when the medical team enters the consultation space. Embodied and verbal resources were important in establishing connection as the medical team entered the consultation space, with establishment of mutual gaze and smiling being important, as has been described as characterizing everyday conversational openings (Pillet-Shore, 2008) and – arguably because - this practice projects a lack of threat (Tomasello, 2008; Enfield & Levinson, 2006).

Participants in this study oriented to an asymmetrical relationship between doctor and patient that characterized their relationship for the consultation. While this is characteristic of many institutional relationships and those between doctors and patients in particular, there were some elements of asymmetry evident in this study that seemed distinctively related to the inpatient setting. Doctors initiated new activities in a way that enacted an asymmetry of interactional control normative for their role in consultations by initiating new activities such as greetings, projecting
levels of formality framing their relationship with patients for the consultation through choice of address terms and greeting formulations and conducting introductions.

However, participants also seemed to orient to distinctive kinds of asymmetry involving elements of relative patient vulnerability in terms of ‘presentation’ as well as of health and residence in an institution with potentially unfamiliar rules and routines that were in any case beyond the patients’ control. Evidence for this included patient jokes at doctors’ expense displaying resistance to medical authority, and doctors’ assurances about the hospital routine, as well as embodied actions such as smiling, establishing and maintaining mutual gaze with patients, touching patients and reducing height differences by sitting by or on the bed during consultations.

How are the distinctive issues and constraints of the treatment of inpatients manifest in the main medical work of the bedside consultation, and how is this work conducted during the central part of the consultation? These questions are addressed at the levels of activity, structural organization and interactive conduct found in the core of the consultation in the next chapter, Chapter 6.
Chapter 6  The core of the consultation

6.1  Introduction

In Chapter 4, the overall structural organization of the bedside consultation as a whole is explored in such a way as to show how participants orient to it in the process of conducting the consultation as a whole event. The point is made in that chapter that consultation components have their own internal structural organizations to which participants orient, and activities that are part of that internal structure are described with reference to a particular consultation chosen as representative of others in this data. Subsequent chapters focus on describing the organization of the three phases of the consultation: the opening, core and closing.

In Chapter 5 the opening is described with these issues in mind, and a particular focus on activities and practices that facilitate work unique to this clinical setting. In this chapter, the core of the consultation, where the bulk of the medical business of the consultation is conducted, is investigated with the same focus, addressing the third research question:

RQ 3  How does the ‘core’ of the bedside consultation unfold?

6.2  Features of the consultation core

The core of the consultation is defined as beginning with the ‘turn to business’ that occurs when the opening activities have been completed (opening activities are shown in Figures 9 and 13 and discussed in Chapters 4 and in more detail in Chapter 5). The transition from the consultation opening to the consultation core may be marked by a transition marker such as ‘now’, and is often launched by a ‘howareyou’ sequence where the first part (‘how are you?’/’how are you feeling?’ etc) is treated as a bona fides inquiry by the patient rather than as a pleasantry or greeting substitute. The consultation core ends when pre-closing and closing activities begin (discussed in Chapters 4 and 7), after the relevant business activities (see Figure 9) have been completed and participants pivot to pre-closing activities, often using a transition marker to do so (e.g ‘alright’ or ‘okay’). The activities of the consultation core are discussed in this chapter.
6.2.1 Duration of the consultation core

In examining the duration of each of the key consultation phases, we gain an insight into how those phases are distributed over time as well as over activities (consultation duration was discussed in §2.3.8). It allows us to see what is quick and what takes participants longer to achieve. It allows us to see how many activities are fitted into different parts of the consultation and how long it takes participants to accomplish them. For example, the opening (discussed in the previous chapter, Chapter 5) is potentially complex in terms of the work done and the number of activities through which that work is accomplished, however its duration is very short. This is an interesting insight into the efficiency of the interactional work occurring at this point of the consultation. It also reminds us of the importance of attending carefully to the detail of interaction which may be fleeting, despite also being important.

The consultation core occupies most of the duration of the consultation as a whole. It occupies an average of four minutes and 43 seconds, which amounts to 90% of the consultation as a whole, which is, on average, just over five minutes.

6.3 Overall structural organization of the consultation ‘Core’

The consultation core starts when the ‘opening elicitor’ occurs. This is the point of transition between the consultation opening and the core and is most commonly accomplished by some form of howareyou sequence. The consultation core finishes at the point where pre-closing activities are taken up by participants and developed into other relevant pre-closing and final closing activities.

“The opening elicitor marks the point at which the participants ‘get down to business’ in the consultation, thus invoking the institutional context of the medical consultation through their talk” (White, 2011:96). In the case of the bedside consultation, the ‘opening elicitor’ may comprise the doctor’s invitation to the patient to provide an update on their progress, in particular, how they are currently feeling. This question, often a ‘howareyou’, launches the activity of verbal examination of the patient as part of the doctor’s information gathering activity that commonly launches the consultation core.
When participants show their understanding that necessary opening preliminaries have been completed and that the time is now right to begin the core medical business of the consultation, the opening is complete, and the core business of the consultation begins. In other settings the purposes of what I call the consultation core have been described as: to establish the reason for the visit, gather additional information, deliver diagnosis and recommend treatment (Robinson, 2003), or: “establishing mutual understanding of the referral and achieving alignment, establishing the patient’s description (and perspective) of their problem, gathering further information … reformulating the problem [and] proposing next steps” (White, 2011:65).

At the bedside the purposes of the consultation core are most often to (re-) confirm the current diagnosis and the efficacy of associated treatment recommendations so far. Other purposes of the consultation core (or business that occurs at this stage of the consultation) are to monitor the patient’s progress in the light of these (and vice versa), and make plans for ongoing care, including possible discharge from hospital, arranging further tests, specialist opinions or post-discharge follow-up checks.

Participants in the bedside consultation orient to an organizational structure that is complex, variable and iterative. The activities through which the work of the consultation core is accomplished are discussed in this section and are shown in Figure 29 (below).
The activities through which the work of the consultation core is conducted is shown in Table 6-1 and also, diagrammatically, in Figure 29 above. As illustrated in Chapter 5, the progression through these activities may be iterative, that is, a previously completed activity may be returned to later, and additionally, not all activities necessarily occur in every consultation. This reflects the differing relevance of activities in particular cases; for example, a discharge discussion is not relevant if the patient is not likely to be discharged from hospital soon. This is evidence of the centrality of local context as a shaping influence on interaction, as CA theory and research findings emphasize (Heritage, 1984).

Participants orient to the general sequencing of these activities shown above, despite the sometimes-iterative pattern of their occurrence. Some of these activities occur often, some less often, and some rarely. The reason for this variability is the fact that the organization of the consultation overall and of its component sections (like the core) is shaped by the local interactional context. This means that relevant issues
for particular participants on particular occasions at particular times dictate
the correspondingly relevant activities they choose to accomplish their aims, and the
way they organize these activities, and enact them.

The range and number of activities that may occur during the medical work of the
consultation reflects the complexity of issues - medical, relational and administrative -
that must be addressed and resolved. This complexity may partly explain the iterative
nature of many consultations mentioned in Chapter 4 and is chiefly evident in
the core of the consultation that is the subject of this chapter.

A summary of activities co-constructed by participants in bedside consultations is
shown in Table 6-1 below. This table marks activities that are distinctive or unique to
this setting in bold, whereas activities that occur during different kinds of medical
consultations or those conducted in other clinical settings, are shown in plain text. As
has already been mentioned, not all the activities shown in the table occur in every
consultation, but this collection represents the range of activities than can and do occur
across a range of individual bedside consultations.

Table 6-1  Activities in the bedside consultation core

<table>
<thead>
<tr>
<th>Activity</th>
<th>Occurrence across the data set (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Opening elicitation</td>
<td>100</td>
</tr>
<tr>
<td>Introductions *</td>
<td>6</td>
</tr>
<tr>
<td>Case presentations *</td>
<td>13</td>
</tr>
<tr>
<td>Specialist feedback request **</td>
<td>40</td>
</tr>
<tr>
<td>Procedure feedback request **</td>
<td>27</td>
</tr>
<tr>
<td>History taking**</td>
<td>90</td>
</tr>
<tr>
<td>Physical examination **</td>
<td>42</td>
</tr>
<tr>
<td>Diagnosis (Appraising current diagnosis, investigation &amp; procedure results)</td>
<td>48</td>
</tr>
<tr>
<td>Treatment (Affirming treatment, test &amp; procedures recommendations)</td>
<td>85</td>
</tr>
<tr>
<td>Discharge planning</td>
<td>73</td>
</tr>
</tbody>
</table>

Note: Activities that uniquely characterize the bedside consultation are shown in bold font.
* These activities sometimes occurred during the consultation core and sometimes during the opening and are discussed in Chapter 5.

** These activities are subsidiary information gathering activities, as shown in figure 29.

6.3.1 Opening business

The business of the consultation core is launched after the opening preliminaries are (understood by participants to be) over, usually by a question asked by the doctor called (Robinson, 2006; White, 2011) an ‘opening elicitor’. The form of opening elicitor varies, and different formats initiate the business of different visit types, chiefly ‘first visits’ and ‘follow-up visits’. Robinson (2006) charts the occurrence of different opening elicitor formats in primary care consultation (n = 15), dividing the data into ‘new concern’, follow up and non-specific (‘other’) formatted first elicitors. In Table 6-3 below, I compare the frequency of Robinson’s opening elicitation categories with those occurring at the bedside. Clear differences are evident. The main business of the bedside consultation is launched in a way that is distinctive compared to how the core of the consultation is initiated in other medical settings. The format of opening elicitation questions that participants use to launch the core of the bedside consultation differs from that of consultations occurring in other clinical settings. This appears to reflect particular contextual imperatives, issues and conditions relevant in an inpatient setting that do not apply elsewhere.

The doctor often initiates the phase of the consultation core by asking a question that elicits engagement and information about the medical situation of the patient at a point where the patient signals readiness to complete opening preliminaries and shift focus to medical business. When the patient responds to this question by treating it as an opening elicitation, a prompt to attend to medical business in a specific way and provides relevant medical information in a specific rather than a general way, the question is successful in initiating consultation business (see Table 6-3 below).

In this way, participants routinely manage the transition from consultation opening to the medical business of the consultation by constructing an opening elicitation. This subsequently makes the activity of gathering information relevant, conducted in
the service of diagnosis validation or diagnosis change. Within the activity of information collecting are a number of interlocking and sequentially interdependent sequences and activities. These include specialist feedback requests (henceforth SFRs), procedure feedback requests (henceforth PFRs), history taking (since last visit), and physical examination.

Completion of the activity of collecting information makes confirmation (or disconfirmation) of the current diagnosis relevant, which in turn makes treatment recommendation relevant. These are all distinct activities that routinely occur during the consultation core.

The term ‘opening elicitor’ refers to the sequence that successfully opens the main ‘business’ section occupying the core of the consultation. The term encompasses actions that can be but are not necessarily questions (White, 2011). In the context of the business phase of the consultation, the term ‘opening elicitor’ is distinct from questions referring to actions found in the opening phase of the consultation that initiate and mark co-ordination of participants’ focus and attention and signals their readiness to work together. The term ‘opening elicitor’ captures situations where questions are not used to initiate the business of the core of the consultation, although it can also refer to situations where questions are used to do this.

The core of the bedside consultation revolves around activities related to a problem that is already known, in most cases has previously been diagnosed, for which treatment has begun, and the (re-) assessment of the validity of that diagnosis is now relevant. Because its focus is a known problem or set of symptoms, the bedside consultation falls into the category of ‘follow-up visit’, and the format of the problem elicitation is similar to that of follow-up consultations described in the literature (Robinson, 2003, 2006; Heritage and Robinson, 2006; Gafaranga and Britten, 2007; White, 2011).

The business of the bedside consultation was usually but not always initiated using a question. Because the reason for the consultation was not unknown, as may be the
case in a primary healthcare setting, new and unrelated issues were less likely to arise in this context than in some other medical contexts. The questions or other actions used as opening elicitors at the bedside are designed to reflect the fact that the person opening business is already familiar with the problem that is the cause of the visit.

Despite the similarity of the priorities and tasks shared between the follow-up consultation in outpatient settings and the inpatient setting at the bedside, the pattern of opening elicitor formats used in bedside consultations differs from that described in community settings (Robinson, 2006). The formats of follow-up elicitors reported by Robinson in a primary healthcare setting (discussed in Chapter 3) differ from the pattern of those used at the bedside. These differences plausibly reflect distinctive issues relevant in this inpatient setting that differ from those issues relevant in other settings such as primary healthcare. These differences are summarized in Table 6-2 below.

Table 6-2 Opening elicitors in follow-up consultations

<table>
<thead>
<tr>
<th>Visit type</th>
<th>New concern question format (%)</th>
<th>Follow up concern question format (%)</th>
<th>‘Other’ concern question format (%)</th>
<th>Total (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary care (Robinson, 2006) n = 15</td>
<td>26.7</td>
<td>66.7</td>
<td>6.6</td>
<td>100</td>
</tr>
<tr>
<td>Bedside consultation n = 44</td>
<td>0</td>
<td>89</td>
<td>11</td>
<td>100</td>
</tr>
</tbody>
</table>

The follow-up format is the most frequently used in questions acting as opening elicitors at the bedside. It is also the most frequently used format in primary care settings, but more so at the bedside, presumably reflecting the fact that as diagnosis is a pre-condition of hospital admission (or at the very least, a set of symptoms that have previously been determined to be potentially problematic and warranting further investigation, in hospital), there is little or no uncertainty about the reason for the visit or doubt about the patient’s presenting symptoms characteristic of the initial primary healthcare visit (documented above by Robinson (2006)).
The fact that in contrast with consultations in other settings, where the patient visits the doctor in his/her consultation room, during in-patient bedside consultations the doctor or medical team visits the patient produces a dynamic where a set of assumptions about the patient’s condition and situation and the level of the doctor’s knowledge about these is reflected in the design of and assumptions built into opening elicitors. For example, questions designed to a ‘new concern’ format are absent at the bedside, whereas they are quite frequently found in primary care settings, whereas questions using a follow-up format predominate, as reported above. The formats of opening elicitor used at the bedside and their frequency are shown in Table 6-3 below.

### Table 6-3 Formats of follow-up opening elicitors at the bedside

<table>
<thead>
<tr>
<th>Format</th>
<th>% Bedside elicitors</th>
</tr>
</thead>
<tbody>
<tr>
<td>‘How are you (today/this morning/Mrs Jones)?’</td>
<td>47 (n = 22)</td>
</tr>
<tr>
<td>‘How are you feeling (today/this morning/Mrs Jones)?’</td>
<td>17 (n = 8)</td>
</tr>
<tr>
<td>‘How are you going/doing (today/this morning/Mrs Jones)?’</td>
<td>17 (n = 8)</td>
</tr>
<tr>
<td>‘How’s your pain/foot (symptom)?’</td>
<td>4 (n = 2)</td>
</tr>
<tr>
<td>‘So you had your skin graft last night?’ (Procedure referring elicitor)</td>
<td>4 (n = 2)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>89 (n = 42)</strong></td>
</tr>
</tbody>
</table>

Table 6-3 shows the contributions made by each of the four follow up question formats to the 89% of the questions used as opening elicitors at the bedside. Robinson (2006) does not provide a breakdown of the relative contributions of each of the three
follow up question formats he outlines. That is, Robinson does not provide a more ‘granular’ or detailed analysis of the sub-types of concern question opening elicitors that he reports make up 66.7% of follow up ‘concern question’ opening elicitors in his primary care consultation data (see Table 6-2 above).

The ‘How are you?’ format, with or without the addition of ‘today’ or ‘this morning’ or ‘Mrs Jones’ (i.e. patient’s name), occur as an opening elicitor in almost half of the documented bedside consultations (47%, n = 22/47). This rate contrasts with the limited occurrence of ‘How are you?’ opening elicitors reported during surgeons’ consultations at only 6% (n = 2/35) documented by White (2011). Robinson and Heritage (2006) also report a 6% incidence of ‘How are you?’ as an opening elicitor during primary care first consultations.

The capacity for ‘How are you?’ to succeed as an opening elicitor depends on its sequential position in the interaction and reflects whether or not the question recipient (the patient) treats the necessary preliminaries to beginning the medical business of the consultation as complete, as discussed in Chapter 5. ‘How are you feeling?’ is used as an opening elicitor in less than one fifth of the consultations in this study (17%, n = 8/47). It works as such by eliciting an evaluation by the patient of his or her “particular recipient-owned currently experienced condition that is known about by the speaker and typically related to physical health” (Robinson, 2006:31).

‘How are you feeling?’ has been shown to “index a particular [and current] health concern” in the context of a medical consultation or during troubles talk (Robinson, 2006:39), and is a way for the doctor to display pre-existing knowledge of the medical issue that is the reason for the consultation. This kind of opening may afford the doctor the means to shift the focus of the consultation from the preparatory work of the opening section to the business of the consultation core, when the details of the patient’s medical condition can be discussed and considered. In shifting the consultation focus in this way, the doctor is able to simultaneously index his or her prior experience with the concern, and by extension, his or her professional expertise.
‘How are you doing/going?’ is used at the bedside as often as ‘How are you feeling?’ (also, in 17% (n = 8/47) of opening elicitations). If these two question formats act in similar ways, then together they comprise an important resource for doctors in initiating the start of business by eliciting an evaluation of the patient’s current perceived state of health, accounting for over a third of opening elicitations (34%, n = 16/47). ‘How are you feeling?’ and ‘How are you going?’/doing?’ both elicit patient evaluations of their own health with regard to current medical concerns, thereby accomplishing transition from consultation opening to commencement of business.

Doctors use question formats that refer to the patient’s current medical complaint obliquely to open business at the bedside much more often than they use question formats that refer to it directly. Direct questions about the patient’s current symptoms or recent procedures are quite rare at the bedside, occurring 4% (n = 2/47) respectively. This possibly reflects the fact that doctors (and patients) generally already knew the nature, seriousness and state of the patients’ conditions and in the light of this knowledge, express the doctor’s sensitivity to this issue by avoiding overtly highlighting it.

Alternatively, when doctors use a direct question format, their focus may be on what is not already known over what is known. It is possible that this is a pattern that characterizes information elicitation in follow-up consultations generally, but as mentioned earlier, that kind of consultation has also not been well documented. This study contributes to knowledge about how a particular kind of follow-up consultation is conducted. Direct questions about the patient’s current symptoms or recent procedures are quite rare at the bedside, occurring 4% (n = 2/47) respectively. Among the occasions when direct questions are used are when doctors initiate procedure or specialist feedback requests (or PFRs, SFRs. These are discussed in §7.3 and subsections).

Robinson and Heritage, (2006) found that patients responded to the perceived opportunity to “present their problems in their own time and terms regardless of how extensively they act on this opportunity” [italics in original] (Robinson & Heritage,
They found that open-ended requests for information embodied a stance that extended patients this opportunity, and that patients felt more satisfied with the experience of (primary care new concern) consultations begun this way. This may explain the clear preference for more open question formats in the opening elicitations evident at the bedside.

Open-ended questions initiating the start of business (compared with closed requests for confirmation) in primary care consultations have been shown to result in longer patient problem presentations (Heritage & Robinson, 2006). However, although Heritage & Robinson (2006) report that patients asked open-ended questions feel more satisfied with the overall experience of the consultation, they do not spend more time describing their presenting concerns; they apparently just appreciate having the opportunity to present concerns in their own time. Open-ended question formats provide recipients with freedom to relevantly frame their responses as they choose. In the context of the bedside consultation, this question format may display and be taken by patients to display acknowledgment of the patient’s perspective by allowing the patient to respond in his or her own terms. Patients, in response, may give longer more expansive responses to questions than they would in response to different question formats. The greater satisfaction patients in Heritage & Robinson’s (2006) study reported in consultations where their concerns were elicited by open-formatted questions (Robinson & Heritage (2006) may reflect a response to the opportunity to exercise greater agency in the consultation as ‘active authorities’.

As mentioned above, ‘new concern’ formatted questions are not used at the bedside, and a higher proportion of opening elicitors have a format different from ‘follow-up concern’ than Robinson reported occurring in primary care clinics. The category of ‘other’ question format includes opening elicitations by patients (that, although rare at the bedside, were absent in primary healthcare settings), for example: P: “Now all I want to know is what they’re going to do to me today” (C27). It is rare for patients to initiate the start of business at the bedside (this happens in 4% of consultations, n = 2), but when it happens in this study, the opening elicitor is a statement rather than a question (C9
and C27). This finding contrasts with findings reported in other work where, while patients in GP consultations do initiate ‘detailing the problem’ consultation phases, they almost never initiate examination or history taking phases (Mulholland, 1994)

Although the statements patients made at the beginning of the consultation core are not elicitors in the sense of being structurally interrogative in the way that questions typically asked by doctors are, they are taken by the patients (the question recipients) as being requests (even demands) for information, and so act as opening elicitors. A statement such as this (Extract 31 below) signal the patient’s willingness to commence consultation business.

**Extract 31 Patient opening business (C27)**

```plaintext
1 P Now all I want to know is what they’re going to do to me
2 [today]
3 D [Well ]
4 you had some bloods taken this morning [by ]
5 P [Yes]
6 D By the sister uh blood ah nurse
7 P Yes
8 (.)
9 D Right well we’re waiting to see: whether the fluids
10 we’re giving you has improved your[kidney function]
11 P [Kidney function]
12 (.)
13 D That’s right
```

The fact that patients rarely initiate business at the bedside may reflect expectations doctors and patients are socialized to have about their respective roles as expert and lay participants in the medical encounter. These roles have an associated distribution of rights to direct the consultation, and responsibilities to acquiesce to that direction, given that the medical consultation is an institutional interaction (Drew & Heritage, 1992). These expectations may include the belief that doctors question, and thereby lead by setting agendas, while patients respond as preferred (by the doctor, as indicated in his/her question design), and follow those agendas. In this way bedside consultation participants appear to orient to an interaction order that characterizes institutional interaction more generally.

Robinson (2003) suggests that the structure of the consultation (in a primary healthcare setting) *itself* is responsible for, or contributes to, a low rate of patient participation and
for patients taking a relatively passive role in the interaction, because it generates a
template of activity and interactive roles where doctors interactively dominate patients,
who accept and submit to this domination that is implicitly justified by the doctors’
professional knowledge and caring role.

The fact that the patient’s initiation of the business phase of the consultation is treated
by doctors as dispreferred appears to be evidence that an interaction order where
doctors set the consultation agenda and direct the course of the consultation is taken
as normative at the bedside. In Extract 31 (C27) (above), the patient takes on the role
of agenda setter and interactional leader normally ‘reserved’ for the doctor, her actions
were met with dispreference markers, overlapping talk and signs of misalignment. In
this example the patient exerts an unusual degree of agency in the context of this
data, and also in relation to what has been shown in the literature about medical
interactions and institutional discourse in general (Pilnick & Dingwall, 2011).

The stretch of talk in Example 48 (above) is characterized by some overlapping
talk. The patient initiates the transition to business by making a topic-initiating
statement prefaced by the change of state discourse marker “now” (line 1). Discourse
markers perform a variety of functions in interaction including signaling ruptures or
disjunctions between units of interaction, conveying a speaker’s stance about a matter
under discussion, and helping to order and direct turn taking. Although a more
detailed discussion of what CA research has shown about the work of discourse
markers is presented in Chapter 3, findings relevant to this passage include the
following.

‘Now’ belongs to a class of discourse marker referred to as ‘misplacement markers’
(Beach, 1995; Bolden, 2006; Bolden, 2014; Schiffren, 1987), as do: ‘okay’,
markers occur at points in an interaction where the current trajectory of the
conversation is interrupted by a diversion or temporary change in direction. The
current speaker uses a discourse marker to show “how the current turn is to be
understood in relation to what has occurred prior to it” (Bolden, 2014:2).
In Example 48, the patient produces the misplacement marker “now” (line 1) when she takes on the role of agenda setting that would normally be exercised by the doctor, by launching the business phase of the consultation. In doing so, the patient not only upsets the normative distribution of interactional rights whereby the doctor leads and directs the conversation, but she explicitly positions her initiation of the business phase as being driven by her wish for more information (line 1) “now all I want to know is what they’re going to do to me today”.

Discourse markers also play a role in the doctor’s response, in this case communicating the doctor’s stance to the patient’s prior action. ‘Well’ has been shown to belong to a group of markers that preface “disaligning or disaffiliative responses, projecting a response that is in some way problematic” (Bolden, 2014:3). Other discourse markers that can similarly display disaffiliation include ‘uh’ and ‘oh’. Here, the doctor treats the patient’s statement as a request for information (Line 3), and the discourse marker preface “well” signals its unusual and dispreferred character. In this way, the doctor’s response emphasizes the normative roles (and associated distribution of interactional rights) of doctor and patient. In so doing, the doctor uses interactional means to sanction the patient for challenging this institutional order. This is reminiscent of the episode in C48 that is discussed in Chapter 5 (§5.3.5.2) where the patient who ‘speaks out of turn’ during the consultation opening is also sanctioned interactionally by doctor.

The section of interaction in this excerpt acts like an inverse history taking sequence led by the patient. The patient provides the doctor with information receipts (“yes” – lines 5 and 7 – and “that’s right” – line 13) in the context of an institutional interaction where it is usual and expected for the expert (the doctor) to take the lead in initiating new activities and topics of inquiry (Pilnick & Dingwall, 2011). The doctor shows that she takes the patient’s action of initiating a new activity (line 1) as being unusual or unexpected and possibly potentially face-threatening (to her, the doctor) by prefacing her response with the dispreference marker “well” (line 3).
The patient continues her directive action regardless, by uttering an overlapping information receipt ("yes") in line 5, and again (this time not overlapping the doctor’s speech) in line 7. The doctor prefaces her continued account of the medical plan with “well” again (line 9), thereby signaling continued discomfort with this order of interactive authority.

Given the capacity of the question structure to set topical agendas and constrain the range of relevant responses question recipients can give (Boyd and Heritage, 2006; Heritage and Clayman, 2010), as well as the epistemic imbalance between doctors and patients regarding the medical issues at the core of the consultation agenda, it is not surprising that when patients do take the lead, they use structures other than questions, and may have preferred statements resting on issues where the epistemic balance is tipped in their (the patients’) favour, such as claims about what they want or feel or have done.

Opening elicitations coded ‘Other’ in Table 5 above also include delivery of test results by the doctor (see Extract 32 below, line 8) as well as history taking questions used instead of opening elicitations (see Extract 32 below).

**Extract 32 Reporting test results as opening elicitor (‘Other’) (C30)**

```
1   D   Good morning
2   P   Good morning
3   D   I’m back
4   (.)
5   P   Oh good ((nods head, leans back, MG)) doctor((smiles, MG))
6   D   Heh heh=
7   P   =Heh heh
8   D   Now once tha your renal function is normal. no not normal
9   (.)
10  no not normal better than it was
11  P   Heh heh heh ((smiling))
```

Examples of questions coded as ‘other’ also include questions with an abbreviated form, usually with an upward final interrogative intonation (e.g. ‘so?’) that convey implicit requests for information from the patient, such as the question following a case presentation that is treated as part of the consultation opening. The doctor seamlessly shifts the interactional focus from giving information to D1 (by outlining the patient’s relevant medical history) to eliciting information from the patient using
the discourse marker ‘and’. ‘And’ can signify an in institutional agenda as well as prompting new activity (Bolden, 2014) as well as maintaining activities across sequences (Heritage & Sorjonen, 1994). In Extract 33, the doctor’s ‘and’ acts as an opening elicitor extending the case presentation to the core phase and ending the opening phase of the consultation with: D: ‘And?’ (line 22).

This excerpt (Extract 33 below) is preceded by an opening phase comprising greetings, introduction and case presentation then opening elicitor marking a sudden ending of the case presentation and opening and shift to business.

Extract 33 Reporting test results as opening elicitor (‘other’) (C1)

<p>| | |</p>
<table>
<thead>
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<th></th>
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<tr>
<td>1</td>
<td>D</td>
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<td>21</td>
<td>D1</td>
</tr>
<tr>
<td>22</td>
<td>D</td>
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</table>

As a result, implicit acknowledgment of the possibility of multiple unexpected issues being raised in the consultation embedded in the term ‘first question’ is less relevant in this than in some other medical settings. In contrast to the situation White (2011) describes with regard to outpatient surgeon visits, the main business of the bedside consultation is invariably preceded by an earlier activity or activities (See Chapter 4).
6.3.2 Gathering information/History taking

Gathering information is an essential part of the medical business of the consultation, as it forms the basis, for the doctor and medical team, for assessing the patient’s progress since the last consultation in terms of the effectiveness of treatments to date or test results that have come in since the last consultation. The leading doctor collects several sorts of information from the patient in various ways at the bedside, in common with consultations in other settings, through verbal or physical examination of the patient, or by visual inspection and observation.

The doctor conducts the verbal examination by eliciting information of various sorts from the patient. The doctor routinely asks the patient about different aspects of how he or she is feeling and experiencing his or her symptoms. They also occasionally ask the patient for feedback about what other visiting specialists have recommended in visits that have occurred separately since the last ward round consultation (what I have called the Specialist Feedback Request or SFR), and to report results from previously ordered tests that might have come in since the last bedside visit. I have called these requests Procedure Feedback Requests or PFR.

The core of the consultation is also an opportunity for the patient to elicit information from the doctors, as is exemplified during the opening in the previous chapter (“now all I want to know is what they’re going to do to me today”, C27).

6.3.2.1 Verbal examination/information gathering

Verbal examination is a form of history taking and is the means by which the doctor elicits the patient’s account of how s/he is feeling in a general sense and with regard to particular relevant symptoms (Boyd & Heritage, 2006; Robinson, 2006; Halkowski, 2006, Heritage & Clayman, 2010), as well (potentially) as with regard to the efficacy so far of previously recommended treatments. It provides information that supplements information gained by other means including visual inspection, physical examination, relevant specialist opinions and test results. As well as being a means for the doctor to gain insight into the patient’s progress using the patient’s perspective and expression of his/her experience of his/her symptoms, verbal examination also
provides the patient an opportunity to articulate his/her experience of current
symptoms and/or changes, developments or other relevant matters.

The activity of verbally examining the patient often follows the pattern (Boyd &
Heritage, 2006) of a series of question sequences consisting of an initial ‘open’
‘Q/wh’ question, (frequently the opening elicitor) followed by a series of more
specific, often optimized, polar questions in response to the patient’s response, and
guided by the doctor’s preexisting agenda for that occasion for that patient, until a
point is reached when the doctor signals his or her readiness to progress to the next
activity, by signaling completion of the current activity, and an orientation to shifting
to a next activity. This pattern is evident in Extract 34 below.

**Extract 34  Verbal examination (C42)**

```
1  D   Now
2   (.)
3  P   Grace can you get the curtain on the other side?
4   (0.3)
5  D   now
6   (.)
7  P   how are you feeling this morning?
8  D   Not too bad but I've got this awful tickle in the throat that's
9   (0.1)
10  P   making me cough cough cough
11  D   Oh
12  P   Just a tickle and no nothing comin’ up
13  D   Okay
14  P   But
15   (0.4) ()
16   (0.1)
17  D   Well your numbers are goo::d
18   (0.2)
19  P   Probably need a bit of fresh air
20   (0.3)
21  D   No:: shortness of breath
22  P   No
23  D   No
24   (0.1)
25  D   did you find that the the nebulizer that we added yesterday
26  P   did you find that helped?
27   (0.1)
28  D   Which one was that?
29  P   We added the Atropen a nebulizer
30  P   Yeah
31  D   Did you find that helped?
32  P   No uh not really no
```
In Extract 34, the verbal examination is structured around five key questions from the doctor: an opening elicitor (line 7), and four polar questions in response to the information provided by the patient in his response to the doctor’s questions (at lines 21 to 32). The open format of the opening elicitor provides the doctor with an insight into the patient’s priorities regarding his symptoms as it simultaneously provides the patient with the opportunity to prioritize the relevant issues regarding ‘how he is feeling’ according to his own criteria.

The activity is consequently organized as a jointly constructed exchange on the subject of the patient’s symptoms and present state. Although the doctor’s questioning is clearly guided by a clinical agenda, the patient’s contributions materially contribute to the shaping and development of the question sequence. The opening elicitor (line 5) prompts the patient to describe a bothersome cough prompted by “an awful tickle in the throat” (line 8). In response to this initial
sequence, which the patient expands following the doctor’s news marker “oh” at line 10, the doctor asks a more specific, optimized (designed with ‘no problem’ formulation) polar question: “no shortness of breath?” (line 21), “did you find that the nebulizer that we added yesterday did you find that helped?” (line 26). Further discussion of the impact of the nebulizer prompts another polar question from the doctor (line) “were you walking around okay?”.

There are occasions during the verbal examination when participants (both doctors and patients at different times) use laughter as a means of dealing with delicate episodes, such as when laughter is used to bracket or interactionally contain talk about potentially embarrassing symptoms (C31), see Extract 35 below.
Extract 35  Doctor using smiling and laughter to contain embarrassing talk (C31)

1  D  Neow:: ((MG))
2  (0.2)
3  tell me about the diabhroea again{(smiles, looks at P, P looks
down, doesn’t smile)} heh heh heh heh
4  P  [Yes well]
5  D  [(He:::h heh heh .hhh(D smiles, nods, MG; D stops laughing and
Smiling when P starts describing symptoms, line 6; D looks at
P))
6  P  I had a bout of diarrhoea {(looks up)}this morning{(MG, D
nods)} which was disappointing
7  (.){(MG doctor nods, looks down)}
8  but I had hoped I was getting better {(MG, D nods)}
9  (.)
10  but I mean as it turns out give a sample {(MG,P nods)} a
normal {(MG, D nods)} one first{(D nods)} then later
11  (.)
12  after
13  (.)
14  about half an hour I had to come back {(MG, D nods)} and
15  (.)
16  it was quite uh
17  (.)
18  difficult to= {(D nods)}
19  D  Yeah
20  P  Uh contain=
21  D  What did it look like?
22  P  Ah like mustard {(MG, P grimaces)}
23  D  Mustard.((MG))
24  P  Uh
25  D  Yellowy stuff?
26  P  Yes {(MG, P nods)}
27  (.){(D nods)}
28  D  Liquid? (MG)
29  (.)
30  P  Yeah {(looks up, grimace, MG, head nod)}=
31  D  Yeah
32  P  Spreading all over {(circular iconic gesture)}
33  the toilet {(grimaces)}
34  D  Lovely {(MG, grimaces)}
35  P  Yeah {(MG, P grimaces then looks away)}
36  D  Heh heh heh heh heh {(looks down, establishes MG) that’s okay.

In Extract 35 (C31) above, the doctor elicits information about the patient’s symptom
as a part of the work of ‘considering the condition’ that verbal and physical
examination help accomplish. Structurally, this activity consists of an information-
gathering phase (lines 1-32), followed by an evaluation and assessment phase (lines
33-35). Both of these phases are initiated by the doctor, although the patient’s response
to the doctor’s questions occupies most of the activity. The information-gathering
phase is a question and answer sequence shaped by the doctor’s requests for
information about (1) the symptom, (2) and elaboration about the symptom (its appearance, lines 22, 25, 28). The activity is completed by the evaluation and assessment phase, consisting of: (1) an assessment by the doctor (line 33) followed up by (2) the doctor breaking mutual gaze (line 35) then a final assessment (line 35).

The doctor displays his understanding of the symptom (diarrhoea) being treated as potentially delicate. He does this by smiling as he asks the patient the initial question (line 3). The patient responds to his smile by looking down and refraining from smiling in response. The doctor upgrades his smile to a laugh following the patient’s ‘refusal of his invitation to smile’, but he laughs alone, while the patient refrains from joining in his laughter. His laughter bookends this delicate, potentially embarrassing discussion about details of the appearance of the patient’s diarrhoea early in the activity of verbal examination, and then at the end of this discussion (line 35) (Haakana, 2001). After the final laugh at line 35, the doctor looks down briefly and when he reestablishes mutual gaze with the patient, he utters a sequence closing assessment that signals a shift to further serious questioning about symptoms in the lines following (not shown here).

The doctor signals the fact that a potentially delicate or embarrassing discussion looms by a stepwise progression to laughter building from a smile (line 3) as he asks the patient to discuss her symptom (D: “tell me about your diarrhoea”) (Haakana, 2010). The patient does not return the doctor’s smile but looks down as the doctor progresses from smile to a laugh. However as soon as the patient begins her response to the doctor’s question, the doctor stops laughing and smiling and attends to the patient’s responses to his questions with a relaxed, attentive facial expression.

This segment of the verbal examination is organized as a narrative, with the patient giving extended responses to the doctor’s open or ‘wh-formatted questions (line 3: “tell me about the diarrhoea”, line 21: “what did it look like?”) and the doctor nods at points of possible turn transition using head nods as embodied continuers and markers of affiliation (Stivers, 2008). At times during the discussion, the patient grimaces (lines 22, 30). At line 33 the doctor produces an ironic assessment (“lovely”) accompanied by a grimace. When the patient
acknowledges this laughable, the doctor then laughs briefly (line 35), before looking down. He then reestablishes mutual gaze with the patient and produces a sequence-ending assessment (“that’s okay”).

There is no further laughter in the subsequent questioning eliciting further specific details about the patient’s symptoms as the activity proceeds. This extract illustrates the way doctors can activate smiling and laughter as a bridge into and then out of sensitive moments or issues arising during the consultation. In addition to this segment being interactionally marked as delicate (by smiling and laughter as discussed above), mutual gaze plays an important role in signaling continued engagement and deployment by the doctor. In addition to this, the doctor uses head nodding as a receipt token in response to ongoing patient informings, also signalling affiliation (Stivers, 2009). Sometimes there is a coordinated exchange of head nodding when the patient articulates a response and the doctor uses a following nod as acknowledgment (lines 26 and 27) or when the doctor nods in acknowledgment of a new informing by the patient which the patient accompanies with a head nod (line 10),

The information-gathering phase features an extended response by the patient to the doctor’s open ‘content’ question at line 3, which takes the form of an extended narrative turn. The only overlap is at the beginning of the sequence, where the doctor’s laughter overlaps the beginning of the patient’s response (line 4: “yes well”). The patient’s turn is punctuated with frequent pauses, possibly marking the delicacy of the topic and/or the patient’s difficulty in finding the right words to convey her meaning. Mutual gaze is maintained for most of the patient’s account, and the doctor passes up opportunities to take the floor at possible TRPs (Transition relevant places see §3.8.4), instead producing head nods that act as continuers, often occurring during pauses.

6.3.2.2 Specialist feedback requests

Specialist Feedback Request sequences (henceforth ‘SFRs’) are a recurrent component of the larger activity of verbal examination at the bedside. SFRs occur when the doctor leading the consultation asks the patient for an account of what a visiting
specialist has recommended or otherwise said during a visit that has occurred since the last bedside consultation. These sequences are like Procedure Feedback Request sequences (PFRs) in that they commonly occur within and function as a component of the activity of gathering information/history taking. SFRs position the patient as the party with more knowledge about the issue under discussion (K+). This gives the patient epistemic authority in relation to an issue relating to expert medical opinion rather than (just) the more canonical realm of patient expertise, namely the patient’s first-person experience of symptoms.

The activity of SFR shifts the epistemic balance in favour of the patient. This (temporary) shift in epistemic authority/asymmetry is distinctive to the inpatient setting, and it reflects part of the institutional order of the hospital routine, where patients have contact with a range of people in a way that is often uncoordinated. SFRs are part of the history-taking/information retrieval activity distinctively characteristic of and recurrent in the bedside consultations. Doctors treat SFRs as performing one of three different functions. These functions are: genuine requests for information; probes aimed at gauging the patient’s level of understanding of a type of information relevant to their situation, namely recent specialist medical opinions or information; and strategies aimed at including the patient more fully in discussion of their current medical situation and condition.

Through SFRs, doctors can request information about the professional opinions of specialists who have visited the patient since the last bedside consultation that is genuinely not known. Such requests are relevant when information about a specialist’s opinion has not yet been directly communicated to the medical physician/doctor conducting the ward round. In these situations, the SFR forms part of the information gathering process through which the doctor tests the validity of the current diagnosis.

Second, SFRs may request confirmation of information already known or surmised by the doctor regarding a specialist’s opinion. In this situation, the doctor may have already received a report outlining the specialist’s findings but be probing the patient’s understanding of what the specialist has told him or her about his or her condition or
situation. When the doctor probes the patient’s understanding in this way, he or she is effectively conducting an additional level of assessment of the patient’s condition examination and assessment process/history-taking.

Third, the doctor sometimes treats the SFR as a way to elicit confirmation about the outcome of a specialist clinician’s visit from the patient, in the service of implicitly inviting the patient’s active participation in the discussion, as well as acknowledging the patient’s knowing role in his or her medical care, and conveying respect for and acknowledgment of the patient, in order for the patient to feel valued and included in the discussion.

SFRs are recurrently designed as polar interrogative questions, while confirmation requests are usually designed as polar declarative questions. Information requests that are delivered as polar interrogative questions constrain the range of possible relevant responses (e.g. to ‘yes’ or ‘no’). As well as eliciting information the doctor needs to proceed with the consultation (e.g. history-taking), such information requests may also act as gestures of inclusion towards patients by doctors by positioning patients as having epistemic superiority in a realm of medical (or medically relevant administrative) knowledge (e.g. D: “did you see Steve [specialist doctor]?”, P: “yes”, D: “what did he say?” in Extract 38 (C46)). In this way SFR’s seem to be a distinctive and versatile practice oriented to by doctors to achieve important objectives in the consultations, including elicitation of information of different types as well as encouraging patient participation, and for conveying acknowledgment of and respect for the patient’s importance in the therapeutic relationship.

The doctor initiates SFR sequences, and occasionally the patient makes a comment that triggers an SFR sequence. When the doctor initiates an SFR sequence, it sometimes occurs quite soon after the beginning of the main section of the consultation, after the opening elicitation, and either before or after the introduction (if there is an introduction) and the case presentation (if there is a case presentation). Alternatively, an SFR sequence sometimes occurs later in the core of a consultation, and there is sometimes more than one SFR sequence in a consultation.
When the patient initiates an SFR sequence, the doctor’s response in opening the sequence after the patient’s triggering action sometimes fulfills one of two main purposes. The doctor sometimes treats the patient’s initiating comment as offering new information that could be used to help assess/evaluate the current diagnosis (C2). In this situation, the initial SFR question is sometimes followed by further questions from the doctor, as characterized in accounts in the literature of history taking in medical consultations in other settings (Heritage and Clayman, 2010).

The patient sometimes initiates an SFR by making a statement that overlaps a doctor’s turn during a doctor-doctor discussion (for example a discussion about the patient’s treatment or some part of the diagnostic process (e.g. C2, line 82; 6:124)), or as a move to introduce a new topic (C2, line 82)

In the Extract 36 below (C2), the patient announces that a specialist has been to visit since the last bedside consultation and that this specialist has suggested an alternative line of treatment. This information is introduced after a series of pauses and a discourse marker ‘so’ that has been shown to preface “other attentive topics” (Bolden, 2008).

**Extract 36    Patient-initiated SFR sequence (C2)**

1   P    Yeah
2        (.)
3   so
4        (.)
5  James Smithers has
6        (.)
7  been in with some alternative approaches to
8        (.)
9  managing the ongoing
10  D   Yeah what did he suggest to you? ((moves forward and orients
11  body to P))

This sequence is structured as an adjacency pair with an extended first part, launched by the patient. The second pair part (line 10), produced by the doctor, consists of an acknowledgment, followed by a second question. There is no overlapping speech, but the patient’s first pair part is punctuated with brief pauses and the doctor’s response cuts in ahead of the natural TRP.
This activity has is treated as an SFR sequence, although it is initiated by the patient and has the format of informing/acknowledgment rather than information request/provision of requested information, as is more usual. This is because the sequence initiates discussion of specialist feedback, which is the focus of SFRs. The doctor orients to this and follows the patient’s informing with the subsequent expanding information request on line 10.

The actions performed by this sequence are those of informing (lines 3–9) and acknowledgment (line 10) of information received, followed by a feedback request (line 10). The doctor’s response orients to the patient’s initiation of the sequence in two observable ways. First, its acknowledgment token (‘Yeah’, line 10) is minimal, possibly displaying a sanction for the patient having launched the sequence. Second, the doctor’s response orients to the initiation of the SFR by using a question to requests feedback about the nature of the specialist’s suggestion. The doctor’s feedback request is followed by embodied and verbal signs displaying engagement and a wish to know more. Further discussion of this topic continues in the following lines.

The patient also appears to orient to the non-normative character of patient-initiation of the sequence by trailing away before completing his informing (line 9 ‘managing the ongoing’).

The fact that in this case the patient has taken the initiative and launched the sequence before the doctor and has thereby upended the normative asymmetry between doctor and patient regarding rights to set the agenda, may explain the pauses in the patient’s turn, as well as the hedging interactional signposting with change of state “yeah”, then “so” (emerging from incipiency and/or shift to institutional agenda, Bolden (2014)).

Questions doctors ask that launch SFR sequences are formatted as requests for information (e.g. ‘Has Dr Jones been to see you?’) or as confirmation (e.g. ‘So the rehab lady has been to see you?’), as
shown in Extract 44. These two formats project different levels of prior knowledge about the subject of the question. An information request projects ignorance on the part of the doctor, while a confirmation request conveys a state of tentative knowing by the doctor, and a wish for confirmation.

Extract 37  Doctor-initiated SFR sequence (C7)

1  D  What did Dr Fellowes tell you about the shaking?
2  P  Not much he said that I don’t think (.)
3                   there is any reason have been sick or something or somebody in the family (.)
4                   I said no (.)
5  P  it’s (same) I started shaking
6  D  Okay (.)
7                   um what is written in the notes (.)
8                   is that you’ve got tremor ( (. (iconic hand gesture, prone down facing))
9                   that is ( .)
10                  sometimes {experienced} ( . (iconic hand gesture prone down facing))
11                 as you get older ( .)
12                  made worse ((metaphoric hand gesture)) sometimes by illness (.)
13                    so you’ve been unwell
14  P  Yes
15  D  It will get better back to where it was before most likely
16  P  Uh heh
17  D  And it’s not a serious problem
18  P  I hope [so]
19  D                 [It] is inconvenient but not
20                  ( .)((iconic hand gesture))
21  P  A serious problem

The example shown in Extract 37 displays the doctor seemingly probing the patient’s understanding of what the specialist concluded about the patient’s diagnosis, through a question design that projects the doctor as K- or not informed. In this extract, the doctor elicits the patient’s understanding of the specialist’s diagnosis by asking what the specialist said during his/her visit (line 1). The doctor’s question is framed in such a way as to also probe the specialist’s way of informing the patient of his/her conclusions.
After the patient’s response to the doctor’s question in line 1 (lines 2 – 5), which displays a possible lack of understanding by the patient of the specialist’s feedback or else a lack of clarity in that feedback, the doctor responds with a change of state and acknowledgment marker ‘Okay’ (line 6), followed by a report of the diagnosis as recorded in the case notes (lines 7 - 8). After relaying the diagnosis (line 8), the doctor goes on to explain what the diagnosis means in terms of its symptoms, possible causes (lines 9 – 12). In line 13 (‘and you’ve been unwell’) the doctor links the condition to the patient’s situation, displaying evidence of the credibility of the diagnosis.

Following her outline of the condition the specialist has diagnosed, the doctor outlines the likely prognosis (line 15), as well as an assessment (‘And it’s not a serious problem’, line 17). The patient displays a possible lack of confidence in the prognosis, (‘I hope so’, line 18), possibly in response to the doctor’s acknowledgment of the chance that the symptoms will not resolve (‘it will get back to where it was before most likely’, line 15). The doctor demonstrates an acknowledgment of this concern by producing with a modifying second assessment ‘it is inconvenient’, line 19), followed by a repeat of her assessment of the seriousness of the condition.

In this sequence, the SFR can be seen to achieve several actions. It allows the doctor to assess the patient’s understanding of specialist feedback while simultaneously involving the patient in the consultation as a knowledgeable authority and source of important and relevant information. In addition to this, the sequence allows the doctor to explain or reiterate the specialist’s diagnosis, focusing on key aspects and providing necessary reassurance and explanation in response to the patient’s comments.
Doctors launch SFR sequences with questions in either of the formats outlined above, namely in a two-part or three-part question sequence (as in Extract 37), or a longer sequence including two or (rarely) more questions (as in Extract 38). In the two examples given above, the shorter format was used to probe the patient’s understanding of the diagnosis and its implications while the second, longer format, was used by the doctor to explore the patient’s response to the specialist’s recommendation (to leave hospital today).


These questions act as either information or confirmation requests, they are designed as polar questions, with either declarative or interrogative form, projecting different states of knowledge on the part of the doctor, which may or may not accurately reflect the actual state of their knowledge. This is sometimes clarified through later remarks by the doctor that reveal prior knowledge about the subject of the question and thereby the real (or main) purpose of the question, namely, to test the patient’s understanding of this aspect of their situation. This is illustrated in Extract 38 above.
6.3.2.3 Procedure Feedback Request sequences

Procedure Feedback Request sequences (henceforth PFRs) are similar to SFRs, although they occur less frequently, in 27% (13/48) of consultations. This is nevertheless quite a frequent feature of the consultation. An example of a Procedure Feedback Request (henceforth PFR) is: D: “Do you know what the results of the colonoscopy were?” (C24). PFRs are similar to SFRs in format and range of possible actions in that they are treated by patients as requests for information. However, the doctor can treat them as probes to help gauge patient understanding of what the test results were and also what they mean to the patient in terms of implications for their current condition.

Patients in this data usually treat PFRs as straightforward requests for information (rather than tests of understanding), and when these requests are not expanded by the doctor, doctors also treat them as straightforward requests for information.

It must be acknowledged, however, that there is some ambiguity in this interpretation, because it is possible that a doctor’s apparently straightforward request for information about events is actually also functioning as a probe of patient understanding. Alternatively, it could be doing both of these things. As analysts we can only observe that when a PFR is not expanded, both parties appear to treat it as a straightforward information request. Doctors sometimes do not develop the sequence further and sometimes instead expand the sequence to an informing, telling the patient what the test results are, in fact. When this happens, the doctor treats the initial inquiry as having been testing the patient’s grasp of the meaning/significance of the results, as mentioned above.

Occasionally the doctor expands a PFR into an explicit inquiry into the patient’s understanding of what a particular test or procedure is, whether it has happened, what the result is and what that means for the patient. In Extract 39 below (C4), the PFR sequence is completed by an informing by the doctor of the result of the procedure, having previously explained what the implications of different results would be.
In this example, the PDR sequence begins with the (junior) doctor leading the consultation requesting information from the patient, asking if the HBA1C test has been done. The patient’s reply, occurring after a pause (line 3) is treated by the doctor as being sufficiently hesitant to warrant a follow up question overtly testing the patient’s knowledge about the test (line 4). After the patient’s response confirms her ignorance about the test, the doctor launches an informing sequence (lines 6 – 17) that culminates in a reporting (line 13) explanation and assessment (lines 16, 18) of the significance of the results. The senior supervising doctor contributes an insert expansion, elaborating (line 14) on the test result reported by the junior doctor (line 13).

This example illustrates the doctor’s sensitivity to the patient’s level of understanding of what procedures and tests have been recommended and performed in response to her condition. When the patient displays a degree of hesitancy in responding to the doctor’s inquiry about whether or not the test has been done, the doctor asks a further question explicitly probing the patient’s knowledge, then explains what the test is and does, what the patient’s results were and interprets their significance.
6.3.2.4 Physical examination

Physical examination usually follows on from a verbal examination, and in common with physical examinations in other settings, patients are required to undress to the point of revealing the area needing inspection. Because these examinations often occur in public settings (shared wards), the patient’s need for privacy is often explicitly attended to (Extract 40 (C29) below, line 15 “could we have the screen around”).

Extract 40 Physical examination (C29)

11 D Okay
12  
13 (0.4) and his admission gases were okay
14 (0.4)
15 could we have the screen around
16 (.)
17 I just want to have a look at
18 (0.2)
19 can we have a listen to your chest this morning?
20 P Yeah
21 D Can you stand up?
22 P Yes
23 (0.1)
24 D We might need this undone
25 (0.2)
26 P Alright
27 take it off =
28 D No no no you sit there
29 (.)
30 just lean forward
31 (0.1)
32 D1 (The doxy .....)
33 (0.5)
34 D Okay so nice deep breaths please
35 (0.6)
36 again
37 (0.2)
38 big one
39 (0.5)
40 again
41 (0.2)
42 okay
43 (0.2)
44 well there's not quite so much rattle but still a lot of cough
45 (0.1)
46 you've still got a lot of cough haven't you
47 P Yeah I coughed all night [really ]
48 D [Oh I'm so sorry]
49 P And but uh
50 D So he's got no right heart right heart failure
okay do you think you're getting any better?

Structurally, this physical examination (Extract 40) consists of three main phases: a preparation phase (lines 11-32), an examination phase (lines 34 – 43), and an assessment phase (lines 44 – 50). The preparation phase consists of (1) shifting focus of action to the physical examination, (2) outlining some relevant facts about the patient’s medical condition, (3) informing (then requesting) the patient of the forthcoming examination and (4) directing and helping the patient position his body to facilitate examination.

The examination phase consists of (1) doctor directives to the patient (about when and how to breathe during examination) and patient compliant responses. The final assessment phase consists of (1) the doctor reporting her finding, (2) the doctor asking the patient for confirmation the continuation of his symptom (a cough), the patient supplying confirmation and the doctor issuing a third-part, sequence-closing assessment (line 48).

The entire examination is bookended by assessments directed to the team at lines 13 and 50, marking the boundaries of the examination. The transitional discourse marker ‘okay’ (line 11) leads into the preparation phase, followed by a statement of the patient’s condition (line 13), preparation of the space (line 15) and informing of the patient by the doctor that she wants to conduct a physical examination (lines 17, 19). The second part of this informing is a self-initiated-self-repair which changes the form of the utterance from a statement (line 17) to a request (line 19). Following this, the preparation continues as doctor and patient work to position the patient correctly for the examination to take place (lines 21-30).

In this example (Extract 40, C29), the doctor explains that she wants to listen to the patient’s chest (lines17 and 19), repairing her initial proposal (line 17) after a delay while the curtain is being drawn around the patient’s bed, by changing its formulation from an informing (D: ‘I just want to have a look at’) to a request (line 19, D: can we have a listen to your chest this morning?’).
This shift displays an orientation to the delicacy of the situation where the patient is being directed, (then requested) to take off his top to be examined in front of a group of people. After the patient supplies permission in line 20 (P: ‘Yeah’) the doctor issues a series of requests for the patient to disrobe and change his body position in such a way as to facilitate the necessary examination (lines 20-43). At the completion of the examination, the doctor provides an assessment of her findings at line 44, followed by a strongly positively valenced (yes preferring) confirmation request (D: ‘You’ve still got a lot of a cough haven’t you?’). The patient supplies the requested (and slightly elaborated) confirmation at line 47 (P: ‘Yeah I coughed all night really’). The doctor at this point acknowledges more than the additional information the patient has supplied and displays understanding of the likelihood that this all-night coughing has caused the patient pain and discomfort. She does this at line 48 with an overlapping sequence-closing assessment displaying sympathy preceded by a news marker ‘oh’ (D: ‘oh I’m so sorry’). The patient responds with an initial expansion but cuts this off at line 49 at the point where the doctor, using the change of shifts the focus of her discussion to a statement addressed to the rest of the medical team informing them of her assessment of the patient’s condition (D: ‘So he’s got no right heart right heart failure’). This assessment is prefaced by the discourse marker ‘so’. This resurrects from incipiency (Bolden, 2006) the larger and prior activity of testing the patient’s current diagnosis against his current condition. The physical examination was a necessary part of this process, and the doctor’s expression of sympathy in line 48 may also be a device for ‘wrapping up’ the activity.

6.3.3 Diagnosis update

The patient’s diagnosis is often not explicitly discussed during the consultation, probably because the doctors are and remain satisfied with the original diagnosis that resulted in the patient’s admission. When a diagnosis or diagnosis update is discussed, this usually occurs in conjunction with discussion about treatment recommendations (see Extract 43 below, §6.3.4) during the consultations in this study, or during the case presentation if one is given.
In some cases, no definitive diagnosis has yet been made, and there is continuing uncertainty while further information is pending from additional tests or exploratory procedures. In the face of this uncertainty some patients display skepticism and nominal acceptance of doctors’ offers of reassurance (C15, Extract 41, below) and others display more overt anxiety (C26, Extract 42 below).

In Extract 41, the doctor offers the patient reassurance about uncertainty surrounding the cause of a recent collapse which led to the patient’s current hospitalization, and also the cause of a previous collapse. The patient’s embodied and verbal responses to the doctor’s reassurance display nominal stoicism and troubles resistance (maintaining mutual gaze, smiling, nodding, continuers, acknowledgements, and thanks at lines 2, 8, 14, 16, 19), however this display is undercut by other embodied actions such as crossing his arms across his body (line 4 and following), looking down (line 19).

**Extract 41** Responses to diagnostic uncertainty: Skepticism, nominal stoicism (C15)

1  D  I I I can’t offer uh
2  no((MG, P smile, head nod))
3  water[tight]
4  P  [No ]((arms crossed across body throughout))
5  D  Explan[ation]
6  P  [No ] ((MG head nod))
7  D  For either the first or the second col[apse]
8  P  Mmm mm mm ((MG))
9  D  But the reassurance that I can offer is that
10  (.)((MG))
11  with
12  (.)((MG))
13  pretty extensive looking
14  P  Mmm ((MG, head nod))
15  D  We found absolutely nothing
16  P  Yeah ((nods, looks down))
17  D  T’ suggest anything [more sinister
18  P  Yeah ((reestablishes MG))
19  okay ((looks down))
20  D  Which
21  (.)
22  P  should be reassuring to you
23  Hmm okay thanks ((looks down))

This activity acts as an account sequence, with the doctor giving the patient an account and the patient acknowledging receipt of the account. Structurally, this is organized as...
a telling or brief narrative, with some overlap and some pausing within turns. There is overlap at the beginning of the doctor’s account (lines 4, 6), where the patient contributes continuers accompanied by head nods. Subsequently, there are several (three) pauses punctuating the doctor’s turns, when mutual gaze is sustained between doctor and patient.

The account conveys an argument for why, despite the lack of a clear explanation, there is no reason for concern about the patient’s recent collapse. Both participants orient to the delicacy of a situation where a symptom severe enough to hospitalize the person experiencing it cannot be explained, despite multiple tests and investigations. The doctor displays awareness of this sensitivity by beginning his account with a disfluent “I I I can’t offer uh … watertight … explanation” (lines 1-5), and he ends the account with the assessment “which ... should be reassuring to you” (lines 20-22).

This final assessment simultaneously orients to the sensitivity of the situation as well as responding to the ambivalence of the patient’s response. The patient gazes at the doctor throughout, produces continuers that display understanding and acceptance of what the doctor is saying, however the fact that these responses sometimes overlap the doctor’s explanation (lines 4 & 6) suggests that the doctor’s words are problematic. Similarly, the patient’s gaze patterns display engagement and affiliation throughout the doctor’s explanation, except at three points when the doctor explains that no explanation has been found (line 15) but that the patient should be reassured (line 22) because no sinister cause had been found (line 17). At these points, the patient looks down, displaying possible disaffiliation with the doctor’s conclusions. The doctor’s use of the word “should” (line 22) also appears to display an understanding of ambivalence in the patient’s responses in line 19 of “okay” but at the same time looking down, rather than maintaining the affirmative connection of mutual gaze. This understanding is displayed in the directive content of the turn: “which ... should be reassuring to you”.

In Extract 42 (C26) below, after a stepwise escalation of the directness of his questions (lines 10, 12, 16), the patient explicitly articulates anxiety about whether he
may have cancer (line 22), linking this fear with the fact that he has an infection (the cause of his hospitalization) for which no responsible bacteria has been identified. He displays unwillingness to accept the doctor’s reassurance that it is unlikely that he has cancer (line 26) and perseveres with questions that eventually oblige the doctor to acknowledge that she cannot rule cancer out (lines 28-29).

**Extract 42 Responses to diagnostic uncertainty: Overt anxiety (C26)**

```
1  P  It’s got into the blood?
2  D  Yes
3         (.)
4  P  yes er well we certainly are growing some something’s growing in
5        the blood
6         (.0.1)
7  D  though we are not sure about the identity of the (noise blocks
8        speech) yet
9  P  (ten lines of elaboration about what tests have shown so far)
10 D  Yeah
11         (.)
12  P  I was going to ask you about that
13         (.)
14  D  because the PSA’s gone from three or four up
15  P  Yeah
16  D  To thirty-four
17         (.0.1)
18  P  and I always worry about what’s going on with the prostate
19  D  If you have a bit of inflammation then the PSA will go up
20  P  (six lines of further discussion about the link between PSA and
21        infection)
22 D  not cancer?
23         (.)
24  D  Ah
25         (.0.1)
26  P  unlikely at this stage
27  D  None of the tests would rule that out though?
28  P  No no the PSA is not specific to say that if it’s up it’s
29        cancer
```

The doctor displays understanding of the patient’s anxiety in her initial slight disfluency in responding to the patient’s question about whether the infection has “got into the blood” (line 1). The doctor replies (lines 4-5) “yes er well we certainly are growing something’s growing in the blood”. Similarly, in response to the patient’s direct question about whether his elevated PSA levels mean that he has cancer (line 22) “not cancer?”, there are pauses (line 23, 25) separating two parts of the doctor’s response: “ah (0.1) unlikely at this stage” (line 26).
6.3.4 Treatment discussion

Treatment discussions are sometimes straightforward and unproblematic in that the patient understands and accepts the doctor’s recommendations. On some occasions however, the patient resists treatment recommendations (C16), and on other occasions (C39, Extract 43 below) the doctors describe their difficulty in choosing the best treatment to recommend because of the complexity of the patient’s condition.
There are two competing problems.

The first is you’ve had a bladder cancer.

Which they have cut out.

But is still bleeding.

Yes?

And the, so what we would like to do is stop that bleeding.

Yes?

Cos you it clearly is going to make you anaemic.

And the second problem is that you’ve got a clot in the lung, for which we want to reduce the capacity of the blood to clot, so we’ve got two competing problems.

We want to make the blood not clot for the lung, but we want the blood to clot for the bladder.

Warfarin for the we’re on Clexane which is the drug that makes the clot, which is making the bleeding worse.

Aided by another drug called Plavix which you need for your stent.

Yes.
111 D  So the combination of the Warfarin and the Clexane
112 (.)
113 and the Plavix makes you bleed
114 (.)
115 P  Yeah
116 (.)
117 D  But your cardiologist Dr Martin
doesn’t want you to stop the Clopidogrel because he’s
119 worried the stent will block
120 (.)
121 P  That’s right
122 D  And we can’t stop the Clexane because you’re at risk
123 from a clot in your lung
124 (.)
125 so now we’ve got to see if we can stop the bleeding
126 (0.1)
127 P  Hm
128 D  So Mr Donnellan clearly wants to go back to theatre
129 and see if there’s anything he can
130 (.)
131 diathermy or burn to stop the bleeding
132 P  Yes:
133 D  Okay?
134 P  Yes
135 D  Otherwise we need to have a think about which agent are we
136 going to stop can we stop the Plavix and look at
137 the risk of stopping the Plasic Plavix
138 (.)
139 which is losing the stent
140 (.)
141 versus stopping the bleeding
142 (.)
143 P  Hm
144 (.)
145 D  So it’s quite complex
146 P  Yes:
147 D  =D’ya think you get it?
148 (0.1)
149 P  I understand yes

6.3.5  Discharge discussion

Discharge from hospital is a fundamental goal of inpatient treatment and
care and consultation participants treat discussion about it as part of the core work of
the consultation. When inpatients leave hospital, they are discharged either directly
home or to a rehabilitation hospital or facility. Arrangements for discharge, including
the timing and place of discharge, are consequently discussed during the bedside
consultation when the patient’s condition makes consideration of post-hospital care
relevant and appropriate.
Discharge planning is usually the last activity on the ‘agenda’ of the consultation core, and it chiefly involves the leading doctor and patient. Discharge planning usually occurs during the core of the consultation (and is therefore treated as an item of medical business), but it can occur during the closing (and hence be treated as a summarizing activity), or during both, or even earlier (for example in the consultation discussed in Chapter 4, where the patient initiates discussion about discharge during the consultation opening).

Discharge planning is a unique task of the bedside consultation that is not relevant in outpatient settings. When patients are discharged from hospital there are two main destinations to which they are sent: home and rehabilitation. Patients are usually discharged either home or to a rehabilitation facility when their medical condition has stabilized or improved to a sufficient degree that they no longer need the intensive round-the-clock care and monitoring available in hospital.

There can be negotiation involved, when the doctor and patient have competing agendas or preferences, and in this way, the activity of discharge discussion shares some features of treatment recommendation (Bolden & Angel, 2017; Stivers, 2006). For example, when the doctor wants to discharge patients to rehabilitation and patients display reluctance and consequent resistance to this suggestion (for example in C7: P: “I’m not ready to go home” and C34: D “if he [specialist] finds nothing ... then you’ll be able to go home tomorrow”/P: “regretfully”), a process of negotiation between the two is evident in their interaction (see §2.3.6). When this happens, patients’ uncompliant responses to doctors’ proposals of discharge impose pressure on doctors to justify those proposals and present more evidence to show that their suggested plan is sufficient to ensure patients’ future care and safety, reassure patients and address their concerns or reservations.

There can be discussion about the process of arranging and confirming rehabilitation-related discharge and admission and of the timing of discharge to rehabilitation. This discussion occurs between doctors, with the patient watching on and listening. The
issue of discharge to rehabilitation is sometimes carefully introduced, reflecting its potentially sensitive nature.

Doctors sometimes raise the issue of the patient’s discharge from hospital to home early in the consultation, perhaps projecting it as a perceived ideal outcome (representing a ‘return to normal [health]’) and therefore ‘good news’ (see C37: D: “you look like you’re ready to go”/P: “yes”) thereby presupposing its more positive valence to patients. Patients’ responses to the prospect of imminent discharge vary from positive and accepting (C48) through guarded or seemingly neutral (C5, C29, C1), to overtly resistant (C7, C34).

Doctors usually initiate discussion about discharge, but sometimes the patient raises the issue first. Interestingly when the patient initiates the discharge discussion, he or she is not always successful in imposing his or her preferred agenda, or in getting his or her proposed agenda item discussed when he or she raises it (as discussed in §4.4.3.3, Extract 5 (C48), or not always immediately (as in C46).

When patients resist the suggestion of forthcoming discharge from hospital, a process of negotiation often follows. This process is often characterized by reassurance or instructions given by the doctor to the patient. When the doctor acts to reassure the patient this reassurance often takes the form of the doctor telling the patient that his or her (the patient)’s condition will continue to be monitored, thus emphasizing the intention of providing the patient with continuity of care beyond the period of hospitalization. This kind of negotiating process is illustrated in C44 (Extract 44 below). The doctor tests the patient’s knowledge and understanding of the suggested discharge arrangements both in terms of timing and location of the place to which the patient will be discharged. In this way, the activity functions as a feedback request, but relating to future care rather than to current diagnostic issues, as does the SFR (specialist feedback request) sequences discussed in §6.2.2.4.

An instance of a discharge discussion where the patient quite strongly resists the doctor’s proposal of discharge arrangements is shown in Extract 44 (C44) below. It
illustrates how patients can push back at doctors’ propositions that they are not comfortable with, and how this resistance may nevertheless ultimately be overcome by the doctor.

**Extract 44  Discharge discussion (C44)**

15 D  Hmm?
16 P  did the rehab [lady]
17 D  [Yes ]
18 D  Come and see you this morning?
19 P  and what did she say?
20 (0.2)
21 D  Ah well she left me a pamphlet to
22 (0.2)
23 P  read oh I've already been to that place before
24 D  Which place was that?
25 (0.1)
26 P  Down at Eastside
27 D  Eastside?
28 P  Yeah
29 D  And so?
30 P  Actually I wasn’t very happy there
31 (.)
32 D  I discharged myself in the finish
33 P  Oh did you tell her that?
34 D  Yeah
35 P  What did she say?
36 D  She said oh
37 (.)
38 P  things have changed a bit there
39 (.)
40 D  Oh okay
41 P  well I hope they have=
42 D  Well I hope they I hope they have
43 P  Did she mention when there might be a bed?
44 (.)
45 D  Did she mention when they might have a bed for you? (.)
46 P  Uhm
47 (0.2)
48 D  Did she what?
49 P  no but the doctor has
50 (.)
51 D  We're the we're a medical doctor
52 P  Yes
53 (0.1)
54 D  he said I'll be here some time
55 (.)
56 P  he didn't say how long a week or fortnight or what I don't know
57 (.)
58 D  Okay well the orthopedic doctor Mr E he wants you to stay another
59 three days
60 (.)
61 P  He's the one who said it would be some time
62 D  So after three days you'll go to rehab
In this example (above) the doctor’s feedback request (line 16-19) triggers a lengthy elicitation of information during which the patient takes the opportunity to overtly and implicitly express his dissatisfaction with the suggested discharge arrangements. The activity concludes with the doctor specifying in more detail what the original proposed arrangements are and announcing that these arrangements will take place (line 62: “so in three days you’ll go to rehab”). At this point, the patient accepts this proposal without qualification, by way of an unqualified preferred response (line 63 – P:”yes”). In other words, the doctor’s announcement makes it clear that the arrangements have been prearranged and that no genuine discussion or negotiation has actually been possible. The patient’s acquiescent response signals his recognition of this apparent reality.

The patient’s dissatisfaction with the proposed arrangements is expressed in various ways through this segment. The patient makes statements that are prefaced by dispreference markers (line 23: “oh I’ve already been to that place before”; line 29: “actually I wasn’t very happy there”). These statements may be given added force by explanatory expansions (line 31: “I discharged myself in the finish”). This aside by the patient claims for himself a level of autonomy and authority in the face of institutional priorities that loomed as more powerful than his own priorities (if they clashed) and were ultimately impossible to effectively oppose.

The doctor acknowledges the patient’s resistance by using discontinuity markers, and sequence expansions comprising further questioning (thereby retaining or regaining control of the agenda). For example, the doctor acknowledges a just prior dispreferred patient response with discontinuity marking oh- prefacing. For example (line 32): “oh did you tell her that?”; (line 38): “oh okay”). This is followed by a sequence ending receipt marker and acknowledgment: “okay”. The doctor also shows understanding of the patient’s perspective by producing evaluations prefaced with dispreference markers, for example (Line 40): “well I hope they have [improved since then as they claim to have]”)
This discharge discussion exemplifies the situation where doctor and patient may orient to competing agendas during discharge discussions. Occasionally patients make insistent requests (sometimes playfully delivered as mock demands – C48) to go home (C48: “I need to go home”, C47: “I may not be here”). Other times patients accept doctors’ proposals of discharge and follow-up plans (P: “I’m quite happy to go along with what you say”, C6; D: “Well then you can go home” (. ) P: “I’m ready to go home.” C37).

Patients’ situations vary, both in terms of their presenting medical problems and their personal situation, and the activity of discharge planning is sometimes a site where conflicting agendas are played out interactively in a process of negotiation between doctor and patient. Stivers (2006) describes how treatment recommendations, unlike diagnoses, are oriented to by participants as being proposals put by the doctor, requiring acceptance by the patient for completion of the activity. In this data, recommendations for discharge plans are oriented to in a similar way.

Discharge discussions are activities where the need for the doctor to respond to both the patient’s medical and social circumstances is particularly evident. It is an area where the agendas of the patient and the doctor can seem to diverge or conflict, reflecting the primary focus of their respective roles as expert/layperson. Patients sometimes attempt to highlight issues that they feel have not yet been addressed or adequately addressed (as may happen to a lesser extent in history taking or accounting for the illness) and doctors may ignore such officially ‘outside the bounds of the discussion’ initiations of patients (e.g. C34: P “I can’t get home alone because I (.) of the stroke”/D: “yes” /P: “and uh (0.2) I really need assistance”). This – discussing discharge proposals - is a site of potential negotiation between doctor and patient.

Patients may resist doctors’ proposals for next steps and present objections and counter proposals (Extract 44 (C44)). However, this example demonstrates the power of the doctor’s authority as institutional agent at the bedside, because in the end, the doctor’s
proposal is the one that is adopted, without modification – imposed even – despite clear protestation against it by the patient.

Although the activity of discharging the patient is not relevant in an outpatient setting, it is crucially important in an inpatient setting. Discharge has both administrative and clinical dimensions. Administratively, it needs to be responsive to the institutional funding-related increasing pressure on available hospital accommodation (beds). This pressure, part of the contemporary (and possibly also historical) realpolitik of tertiary medical care, likely results in implicit pressure on medical teams to treat their patients as quickly as possible to the point where discharge is relevant and can reasonably be recommended. The pressure on doctors to free up beds as quickly as possible for other patients is seldom explicitly referred to, however it appears to emerge implicitly in the discharge discussion.

For this reason, rehabilitation in institutions that bridge hospital and community care is important as it provides continuing care for patients whose condition is not yet sufficiently stable for release back into independent community living but is no longer so acute that hospital treatment is the only appropriate option. Many patients, particularly those with multiple medical problems, move from hospital to a rehabilitation facility rather than directly home from hospital (see Extract 44 (C44)).

Discharge to ‘rehab’ is not the only form of discharge that occurs in this data or that is discussed at this point in the consultation. Some patients are discharged directly back into the community (See Extract 45 below, C10). Some of these patients need relatively complex post-discharge monitoring, whereas others need only minimal follow-up. Doctors and patients discuss plans for post-discharge patient care and monitoring in an activity that often forms part of the discharge discussion. As with other issues that arise during the consultation, the complexity of these arrangements varies.

**Extract 45  Discussing next steps (C10)**

27 D Jim Connellan is important to follow up with
28 (.)
29 P Yeah
When you get home

Yeah

We know he's on leave at the moment so Jim's back and around

He's back tomorrow

Do you have his number?

Yes I've got the number

When he's back tomorrow

so give him a call next week

And catch up with him Nick

and we

would love to see you again

in our clinic

and we'll make an appointment for you

Yes

That you'll get in the mail

and we'll see you

around the time that the antibiotics are finishing

so after the antibiotics are finished

Hmm

We'll get you to get another urine sample in the community

Hmm

Make sure

we've cured

and killed all of the bugs

( )

'nd see us in clinic on a Friday afternoon

and that's just across the road

Yep

( )

no problems

6.4 Summary and following chapter

In addressing the third Research Question: ‘How does the consultation core unfold?’ this chapter illustrates the organizational and interactional complexity of the
work of the consultation core at the bedside. It shows that participants in the consultation orient to the core medical business of the consultation being relevantly achieved through a series of activities following on from the opening and progressing through to the closing, sometimes in an iterative manner. These activities are managed by the doctor to assess the patient’s condition, confirm the current diagnosis, establish the level of patient understanding of these and other issues relevant to the patient’s condition, progress and trajectory towards hospital discharge. Several of these activities are unique to the inpatient setting and they reflect distinctive issues, constraints and dilemmas confronting participants in this kind of consultation. These are: SFRs, SPRs, and discharge discussions.

Specialist recommendation and/or procedure feedback requests characterize this inpatient clinical setting, and are an example of disembodied team health care, with the care of the patient distributed between doctors who are present and doctors who were not. As such, they are evidence of the complexity of health care delivery in this setting. In this way a specialist feedback request projects the relevance of the patient giving his/her own mini case presentation.

Doctors display sensitivity to delicate issues by spoken and embodied means at different points of the consultation. These delicate issues include topics that may be embarrassing, or overt or implicit displays of anxiety by patients, for example in the face of uncertainty over diagnosis. Patients employ embodied and spoken resources to push back against proposals they disagree with (for example during discussions about discharge), as well as to display a range of responses in the face of issues such as uncertainty, vulnerability (e.g. about leaving hospital, or having to remain in hospital, or in having concerns ignored.

During the consultation core, participants in the consultation generally orient to an asymmetrical interactional order where doctors predominantly drive the interactional and clinical agenda (by initiating new activities for example). However, patients at the same time have the resources to push back against these, and they sometimes use these resources to assert interactional agency by pushing back and resisting doctors’ proposals and interpretations.
Overlaying the activities and interactional dynamics outlined above, the consultation core shows how the multiparty and multi-purpose nature of the inpatient medical team is managed. The educational and professional socializing aspects of the consultation is evident in both the embrace of silent, onlooking audience roles by participants other than the doctor leading the consultation and the patient, and the periodic inclusion of junior doctors individually or collectively by questions by the leading doctor. Similarly, family members take on observing roles, seldom actively participating in the interaction.

The next chapter addresses the issue of how the consultation is brought to a close at the bedside, focusing on the activities participants co-construct in order to achieve this objective and the orientations they display towards the normative institutional framework of the consultation.
Chapter 7  How the consultation is closed

7.1  Introduction

This chapter continues the exploration of the organization and conduct of the bedside consultation begun in earlier chapters. Following on from examinations of the consultation as a whole and of its opening and core sections, this chapter focuses on the consultation closing.

Closing an interaction is a complex achievement. This undertaking is jointly conducted by participants in the interaction through a series of activities that lead to the point where they can disengage physically, emotionally and interactionally, and the consultation can relevantly end. The issue of how this disengagement is brought off in an inpatient setting is the focus of this chapter, which addresses the final research question:

RQ4  How is the bedside consultation brought to a close?

In this chapter, the organization of the closing section of the bedside consultation is considered with reference to observations made in Chapter 4 but illustrated with examples from across the data set. The chapter focuses on activities participants deploy to achieve their aims for this part of the consultation and treat as normative in doing so. As in Chapters 5 and 6, this chapter begins with observations about patterns observed across the data set regarding duration §7.2.1, participation patterns §7.2.2 and the role and design of questions §7.2.3 in the closing, as well as pre-closing activities (in §7.3.1.1), components of arrangement-making (in §7.3.1.4), closing activities (in §7.3.2), and terminal sequences (in §7.3.2.3).

Following these preliminary sections, the overall structural organization of the consultation closing is outlined and discussed. As was the case with the consultation opening, technical issues occasionally resulted in the closing section not being recorded in full or at all. This means that not every consultation closing phase was available for analysis. The total number of consultations for which data was collected
is 46. On two occasions, data was not recorded because one or more cameras unexpectedly ran out of ‘charge’ before the consultation had ended.

7.2 Features of the closing: duration and participation patterns

7.2.1 Closing duration

The closing of the consultation is understood to occupy the time between the beginning of pre-closing activities and the departure from the consultation space (§3.6.2) of the consultation. Consultation closings at the bedside are relatively brief, occupying on average 8% (23 seconds) of the total duration of the consultation (§3.8.4.2). The closing sections of changeover consultations are slightly longer than those of regular consultations (changeover closings occupy on average 9% of the consultation, or 26 seconds), but the difference is (probably) not statistically significant. Consultation closing duration ranges from 53 seconds to 9 minutes, 31 seconds (C25)).

7.2.2 Participation patterns

7.2.2.1 Activity initiation

Participation in the consultation can be viewed in terms of the distribution of turns at talk between participants, or in terms of the distribution of actions initiating new activities. In common with other sections of the consultation discussed in earlier chapters (Chapters 5 and 6) participants in the consultation closing orient to the relevance of doctors initiating most types of closing activity at the bedside. Doctors routinely initiate activities including closing last topics, summarizing the condition, eliciting final concerns, making, summarizing or reiterating arrangements, terminal sequences and breaking co-presence.

However, the opposite is true of thanks sequences (§3.8.4.2), which are exchanges of ‘thank you’s that characterize many closings in this data. These are routinely oriented to as being relevantly initiated by the patient. Participants orient to the relevance of either doctors or patients initiating pleasantries. Examples of all these kinds of activity initiation are discussed in the sections below.
7.2.2.2 Questions in the consultation closing

Questions have been shown to characterize medical discourse in many settings (e.g. Boyd & Heritage, 2006), and they are in this data as well. I have chosen to examine questions in this part of the consultation for the practical reason that at other sections of this study, there was so much to consider that this final part had more space to accommodate the discussion. Table 7.1 below, however shows the distribution of questions throughout the consultation, so it gives a snapshot of the pattern of this important kind of activity initiating action throughout the encounter.

An examination of who asks questions, how questioners design their questions and what actions those questions accomplish at different stages of the consultation, gives us some idea of how this powerful and culturally ubiquitous resource is deployed by participants in the bedside consultation. It is beyond the scope of the current study to fully investigate the role of question sequences at the bedside, and it would be an interesting topic for future research. In this section a brief overview of the role and nature of questioning during the consultation is presented. Question types and sequences are outlined in §3.8.4.2, and in Stivers & Enfield (2010).

The power of questions as a way of directing talk and thereby pursuing agendas, lies in their characteristic of being first parts of adjacency pair sequences that make (1) responses and (2) particular types of responses (answers) relevant. In other words, questions impose pressure on recipients to supply particular types of responses, and of being held interactionally accountable if they fail to do this, thereby putting the questioner in control of the agenda of the interaction at that point.

Questions therefore provide the means for doctors in particular (but also patients) to direct and shape interaction during the consultation closing. Question sequences are a powerful and versatile way to achieve various closing tasks at the bedside. Doctors, who take just over half the speaking turns during the closing (see Figure 25 above), ask disproportionately more questions – 69% (n = 39) than patients (27%) or others (3%). This is consistent with the directive role they play throughout the consultation, given the constraining character of questions and the way they consequently powerfully direct the course of conversation. Indeed, doctors ask many more
questions than patients or others (such as family members) at every stage of the consultation as can be seen in Table 7-1 below:

Table 7-1  Distribution of questioners through the consultation

<table>
<thead>
<tr>
<th></th>
<th>Opening</th>
<th>Consultation Core</th>
<th>Closing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctor</td>
<td>71</td>
<td>78</td>
<td>69</td>
</tr>
<tr>
<td>Patient</td>
<td>22</td>
<td>22</td>
<td>27</td>
</tr>
<tr>
<td>Other</td>
<td>7</td>
<td>0</td>
<td>4</td>
</tr>
</tbody>
</table>

The figures shown represent percentage of questions asked by different categories of participant in each phase.

This directive role of questions in the closing is intensified by the fact that the overwhelming majority of questions have a polar design (92%, n = 51), with the few remaining (8%) having content or wh- design. Polar question design intensifies the directive capacity of the question sequences they initiate because polar question design is highly constrained in terms of preferred response form and content it makes relevant. The distribution of question design in the closing section of the consultation is shown in Figure 33 below, while Figure 34 shows how questions are used (i.e. what actions they perform) during consultation closings, in terms of the actions they accomplish.
The main action accomplished by questions during the consultation closing is requesting information (59%, n = 33), followed by requesting confirmation (39%, n = 22) and ‘outlouds’ (2%) (For examples see Appendix 7, §3.8.4.2). The distribution of these actions is shown in Figure 34 above. This finding may provide insight into the relative importance of different components of arrangement making, given its importance during the consultation closing, as well as elicitation and presentation of final concerns. The fact that patients ask relatively more questions during the closing may be evidence that they have more opportunity for verbal involvement during the closing than earlier in the consultation, through participation in arrangement making and articulating final concerns.

7.3 Overall structural organization of the consultation closing

In the closing phase of the consultation, participants progress from a state of communicative engagement to disengagement in a process that mirrors (in reverse) that of the opening. Mutual attention and engagement are necessary for achievement of the work of the consultation to succeed, and when it is complete, participants are free to progress to other activities and to disengage mentally, emotionally and physically from each other. This process of disengagement is frequently ‘messy’,
reflecting the delicacy and complexity of disengaging attention and connection at the completion of business. Although closings in other consultation settings may also be messy, there are distinctive uncertainties that are often relevant for inpatients not shared by outpatients.

The closing phase of the consultation in this data is often characterized by incomplete adjacency pairs (where second pair parts are absent), pauses within and between turns, the insertion of episodes of small talk or the re-activation of previously completed activities such as reiteration of arrangements, the pursuit of solutions to previously unsolved problems or the explanation of a diagnosis or treatment plan. Sometimes the consultation itself is reactivated after having been closed, by means of doctors who have left the consultation space returning to initiate a new activity or activity sequence, such as information collection regarding patient symptoms.

**Figure 32  Overall organizational structure of the consultation closing**

The closing phase of the consultation can be divided roughly into two sections, those of pre-closing and closing (see Figure 35). The pre-closing and closing sections typically display an internal structural organization comprising a number of activities, shown in Figure 36 below.
The following activities occur during these sections and facilitate progression towards a final termination of the consultation and are discussed during this chapter in the following sections: Pre-closing (§7.3.1). This section includes completing (“bounding off and shutting down” (West, 2006:385)) a last topic (§7.3.1.1), summarizing the condition (§7.3.1.2), eliciting final concerns (through final concern elicitation sequences) (§7.3.1.3), and making, summarizing and/or reiterating arrangements (§7.3.1.4). Final closing (§7.3.2). This section includes thank-you sequences (§7.3.2.1), pleasantries (§7.3.2.2), farewells/terminal sequences, (e.g. ‘bye’/’bye’), (§7.3.2.3), and breaking co-presence (§7.3.2.4).

As with earlier parts of the consultation, participants orient to the interactional authority of the leading doctor whereby he or she (the doctor) generally initiates new activities and thereby projects the consultation forwards. Although the doctor
generally sets the agenda and pace of the consultation, during the closing section of the consultation patients frequently assume a directive role by initiating thank you sequences. This is a pattern previously described in relation to community medical settings (West, 2006).

At the bedside, the medical team leaves the consultation space at the end of the visit. The communicative work of the closing is to reach the point where a turn is made which does not make a response relevant and is treated as final by both or all participants, and the work of the consultation complete. At this point, a final turn is taken that is designed so that no response is relevant. At this point, silence follows, the interaction ends, and the medical team (whoever that consists of) leaves the bedside.

Manoeuvering the consultation to a point of closure can be complex, and points of possible closure sometimes occur multiple times during a consultation, sometimes initially quite close to its opening. For example, in one consultation, the (junior) doctor made a number of attempts to initiate pre-closing which were not developed towards final closure, which was itself only achieved after a consultation lasting over ten minutes (as occurs in C25 – transcript not shown). These points of potential closure are enacted by pre-closing actions, with two possible results. The first is that pre-closing moves can be followed by a closing move or moves that are responded to as such and that leads on to termination of the consultation. Alternatively, pre-closing actions can be followed by the introduction of a new topic or extensions of current or previously introduced topics and are consequently not accepted and are therefore unsuccessful in generating the conversation close.

The medical work of the consultation closing is generally driven by the doctor and consists of some or all of the following tasks: the doctor may conduct a final verbal or physical examination of the patient, giving the patient the opportunity to clarify residual misunderstandings or confusion over what had been discussed during the consultation; and reiterating plans for treatment, further testing or investigation, discharge and/or post-discharge review, and future care.

When the bedside consultation reaches the point of final closure, the doctor displays an understanding that all relevant medical issues have been addressed and resolved to an
acceptable degree, by acting to terminate the consultation, and leave the patient until their next consultation together. The doctor also orients to needing evidence that the patient understands and accepts his or her medical situation, as well as the recommendations and interpretations of the situation agreed upon during the consultation. The doctor also orients to the need for evidence that the patient is ready to be left to continue or rest or participate in whatever treatment or care has been agreed to and arranged during the consultation.

The patient orients to the need to be willing to accept agreements reached with the doctor over the course of the consultation regarding the current diagnosis and associated care and treatment approaches and recommendations. The patient also orients to the need for willingness to relinquish the attention and companionship inherent in the bedside consultation, and to resume the more solitary experience of recuperation or treatment required for the following part of his or her hospital stay.

In the context of the bedside consultation, failure of an attempt to bring the consultation to a close may reflect a number of possibilities. When the doctor moves to close the consultation, this displays an understanding that the work of the encounter has been satisfactorily completed, leaving him or her in a position where they can reasonably take their leave and move on to their next commitment. When the patient accepts such an offer, it conveys an understanding that the doctor considers the business of the consultation to be complete, wishes to end the encounter and acceptance of that proposition. The same applies when the patient makes a closing move, although this situation is less common than that of the doctor initiating closing. Acceptance by a second party of a closing move made by a first party results in termination of the interaction.

### 7.3.1 Pre-closing

Activities that recurrently occur in the early pre-closing section of bedside consultations are described in this section. They are closing last topics (§7.3.1.1), summarizing the condition (§7.3.1.2), final concern elicitation (§7.3.1.3), and making, summarizing and/or reiterating arrangements (§7.3.1.4).
Shifts within the pre-closing sequence from preparatory pre-closing actions to pre-closing actions ‘proper’ are often marked by a transition marker sequence (e.g.: ‘okay’ / ’okay’ ) before final concern elicitation and arrangement making.

### 7.3.1.1 Closing last topics

Preparations for pre-closing such as discussion of possibly last topics, are relatively uncommon in this data. This is particularly true of summaries of what has gone before, which occur in 22% (10/46) of consultations. When these occur, they generally take the form of summaries of the patient’s symptoms or condition, or of a discussion among the medical team about some aspect of the current treatment and the patient’s symptoms (e.g. Extract 46 below, C1). Sometimes this kind of pre-closing discussion leads into a new episode of history taking or other discussion (in 13% or 6/46 of consultations) resolving outstanding medical or other issues and delaying progress through pre-closing towards final closing.

The doctor usually initiates the first pre-closing action, however possible pre-closures are never initiated by explicit announcements of closure at the bedside (for example [not from my data]: “I’ve got to go”, “we’ll have to finish up there”, “I’ll have to go to see my next patient now”). Initiation of pre-closure does not, however, necessarily lead to closure, because new topics can be introduced, or old issues reprised, as exemplified in § 7.2.2.3 (below).

Pre-closing is often initiated by discourse markers that indicate a change of direction, for example, “okay + alright” and also “very good” that follows the “analyzable (to participants) end of a topic” (West, 2006:266). In Extract 46 (C1) below, the leading doctor’s sequence ending “okay very good” (line 5) follows a pre-closing final arrangement-making sequence launched by shift-implicative ‘so’ (lines 1–3) D ‘So if there’re any concerns before you see me next week (0.1) you can ring the mobile.’ This leads to a farewell/goodbye sequence and a final patient thanks, which does not receive a fitted response – or even an immediate response – but rather a final “bye bye” from the doctor (line 10). The doctor’s “okay very good” is treated as a pivot away from the arrangement making (“Okay”) and topic-closing “very good”, 319
is followed – and overlapped - by the FPP of a farewell sequence (line 6), although this is initiated by the other doctor. The leading doctor however takes up the farewell sequence and the patient’s final thank you (line 8)322 is followed by a final farewell (line 10) from the doctor.

**Extract 46  Closing last topics (C1)**

1 D So if there’re any concerns before you see me next week
2   (0.1)
3 D You can ring the mobile
4 P Terrific thank you very much
5 D Okay[ very good]
6 D1 [Bye bye ]
7 D [Bye bye now]
8 P [Thank you ]
9   (.)
10 D Bye bye

Such pre-closing discourse markers occur at natural or created topic ends and they create ‘empty topics’, namely turns that ‘pass’. These can then be followed by an exchange: ‘ok’/’ok’, but may not be, as seen in the example above.

Possibilities exist throughout the pre-closing section to introduce or reintroduce “unmentioned mentionables” (Schegloff & Sacks, 1973) and thereby extend the conversation. Discussion about or confirmation of previously agreed arrangements often act as preparation for pre-closing, and this was generally initiated by the doctor.
Table 7-2  Frequency of pre-closing activities at the bedside

<table>
<thead>
<tr>
<th>Activity</th>
<th>Frequency across the data set (%), n = 46</th>
</tr>
</thead>
<tbody>
<tr>
<td>Final concern elicitation (doctor initiated)</td>
<td>26</td>
</tr>
<tr>
<td>Discussion of final concern</td>
<td>13</td>
</tr>
<tr>
<td>Making arrangements (new and previously agreed)</td>
<td>80</td>
</tr>
</tbody>
</table>

Note: (1) these activities are not mutually exclusive and can co-occur. For this reason, the percentages do not add up to 100%.
(2) the endings of some consultations were not recorded hence the number of pre-closing activities is n=46

When the doctor offers the patient the opportunity to raise any previously unmentioned or unresolved concern through a final concern elicitation, this usually occurs early in the closing. This kind of offer is, however, a relatively uncommon action, occurring in 26% (17/46) of consultations. For example:

**Extract 47  Final concern elicitation (C45)**

1  D  Alright Sally.
2  D  (.)((turns to P and establishes MG))
3  D  any questions?
4  P  Not a thing.((shakes head))
5  D  Okay ((touches P wrist, breaks MG & turns
6  D  away)) alright. we’ll leave you to it

Here (in Extract 47, C45) the final concern elicitation is a clear unit of activity. It is bounded by the discontinuity marker ‘alright’, which initially signals a change in direction from earlier talk (line 1), something reinforced by the doctor’s establishment of mutual gaze with the patient after turning to face her. At the end of the activity, the doctor again says ‘alright’ (line 6), this time preceded by ‘okay’ (line 5).

‘Alright’ has been shown to be sequence closing while the sequence of ‘okay’ + ‘alright’ has been shown in other contexts to mark the closing of a larger order activity (Beach, 1993; Bolden, 2014).

To further reinforce the sequence closing action of this passage of talk, the doctor follows the sequence closing ‘okay alright’ with the announcement ‘we’ll leave you to it’ (line 6). At the same time, the doctor reinforces these finishing utterances with the embodied actions of touching the patient’s arm as he
speaks to her then breaking mutual gaze and turning away prior to leaving the interaction space.

The doctor offers the patient the opportunity to raise final concerns using a negatively valenced polar question “any questions?” (line 3), to which the patient provides a preferred ‘not a thing’ response (line 4). The doctor then produces a third part assessment (‘alright’, line 6) followed by an extension pre-closing announcement (line 6) D “we’ll leave you to it”. The doctor’s assessment (“alright”) signals a further change of direction and doubles as a sequence closing discontinuity marker, prefacing the announcement of the team’s imminent departure.

Final concern elicitation sequences are discussed in more detail in §7.3.1.3.

7.3.1.2 Summarizing the condition

Participants in the consultation sometimes oriented to the relevance of the activity of summarizing the patient’s condition (see Extract 48). The doctor was treated as the relevant participant to deliver such a summary, which often preceded presentation of the proposed plan for next steps and was sometimes treated as an updated diagnosis. These summaries could be lengthy if the issues outlined were complex, as in the following example (Extract 48), which is discussed in greater detail in §6.3.4. Here the doctor’s explanation was marked by pauses that followed individual components of her account. During these pauses, the doctor used gaze to elicit the patient’s display of understanding before continuing.
Extract 48    Summarizing the condition (C39)

1   D   There are two competing problems
2    (.)
3   the first is you’ve had a bladder cancer
4    (.)
5   P   Yes
6   D   Which they’ve cut out
7    (.)
8   P   Yes
9   D   But is st
10    (.)
11  still bleeding
12    (0.1)
13  P   Hmm
14  D   Yes? And the
15    (.)
16   so
17    (.)
18  what we would like t’do is stop that bleeding
19    (.)
20  P   Yes
21  D   Cos you (.).
22   P   Yes
23  D   And the second problem is that you’ve got a clot in the lung
24    (.)
25  P   Oh
26  (0.2)
27  P   Oh

This relatively complex summary was treated by the patient as a narrative or (story)
telling, with the information receipt tokens or continuers (“yes”) being produced by
the patient after the doctor provided each new piece of information that was followed
by a pause during which the doctor used gaze to elicit a response from the patient. At
the point where the crux of the treatment dilemma became clear to the
patient (namely that she had two competing problems urgently
requiring opposing kinds of remediation: bleeding needing stopping and clotting
needing prevention), she (the patient) produced a discontinuity
marker, “oh”, that simultaneously displays understanding of the dilemma
the doctor describes and also a news marker that identifies this information as
news. In other words, the patient’s
disaffiliative “oh” response displays her understanding of the problem outlined
by the doctor’s explanation.

Examples such as the one discussed above illustrate how issues prompted by pre-
closing summaries of the patient’s current condition may arise, and  further
discussion. An example of a new conversation topic or question prompted by a pre-closing summary of the patient’s condition, or of an issue inadequately addressed in the summary is shown in Extract 49 (C39) below.

In Extract 49 below, the patient is prompted to express confusion about an aspect of the bleeding she is experiencing:

**Extract 49  Issues arising from the summary (C39)**

1  P  Uh just
2     (.)
3  what I don’t understand is why
4     (.)
5  at night it can be fine
6     (.)
7  you know I’m almost back to normal
8     (.)
9  and the next morning something like this happens
10    (.)
11  what causes it?
12    (0.1)
13  overnight?

After the patient announces that she doesn’t understand the reason for the pattern of bleeding she has noticed (namely the fact that she experiences profuse bleeding in the morning but none at night. This passage is not shown here.), the doctors discuss possible explanations for the issue.

The senior doctor leading the consultation uses this discussion as an opportunity to allow the registrar in the team to attempt to solve the problem of what might be causing this pattern of bleeding, by suggesting possible explanations. In this example a summary of the patient’s situation-prompted discussion of a previously unmentioned aspect of the patient’s situation. It also subsequently was treated by the doctor leading the consultation as an opportunity for teaching and for a junior doctor to display diagnostic problem-solving skill as well as responding to the patient’s concern about the causes of the bleeding.

**7.3.1.3  Final concern elicitation sequences**

As the consultation draws to a close, doctors sometimes provide patients with the opportunity to raise issues that have not previously been addressed in the consultation.
or concerns that have arisen for patients during the consultation, but which have not been resolved for them. This activity is referred to here as *final concern elicitation*.

Final concern elicitation sequences occur as part of the consultation closing in only around a quarter of consultations in the study data (see Table 7-2). However, due to the (previously discussed and illustrated) iterative nature of the consultation structure, a similar number of final concern elicitation sequences occurred during the consultation core, suggesting either that participants orient to final concern elicitation as being part of the core work of the consultation or alternatively that final concern elicitation is an activity that doctors sometimes initiate in unsuccessful attempts to bring the consultation to a close at what turn out to be an earlier point.

Doctors initiate the activity of final concern elicitation as part of the process of bringing the consultation to a close. Final concern elicitation sequences give patients the opportunity – at least nominally – to raise issues that remain unresolved in their minds or that have arisen in the course of the consultation but that the patient has not yet mentioned for some reason, ‘unmentioned mentionables’ (Schegloff & Sacks, 1973).

These elicitations are often negatively-valenced, ‘no-preferring’ polar questions, e.g. (C7) D: “*Any questions?*” or (C32) D: “*Anything else we can do for you?*” in line with the practice of designing no-preferring final concern eliciting questions in such a way as to discourage patients from extending the consultation documented in other clinical contexts (Heritage & Robinson, 2011). This furthers an agenda that orients to the bedside consultation (and more broadly, the ward round visit) as being part of a larger institutional hospital routine, which imposes time pressure on the doctor and medical team.

Patients usually submit to the constraints imposed by the question design of the final concern elicitation. In doing this, patients orient to the negative valancing of these questions by not raising new concerns or queries about what has previously been discussed. In conceding to this negative valancing, patients possibly also orient to a normative expectation that the opportunity purportedly offered by final concern
elicitation is not genuinely offered but rather is issued for the sake of ‘form’ and/or the (doctor’s) fear of being responsible for not giving the patient a final chance to ask questions.

**Extract 50  Final concern elicitation (C3)**

110  D   Anything you want to ask?
111  P   No I don’t think so no

In Extract 50, the patient concedes to the constraints of the doctor’s no-preferring question (line 110), but in a response that is hedged by the addition of “I don’t think so” before the original conforming, negative response is repeated in “no”. This hedging may express pressure the patient feels to meet normative interactional expectations and suppress remaining concerns in the service of the overall structural organization of the closing that both parties orient to or to the (unmentioned) constraints of time pressure.

Occasionally the doctor expresses appreciation of the fact that the patient cooperates by giving the desired response to his question. In Extract 51 below, the doctor explicitly highlights the patient’s orientation to the constraints of the no-preferring final concern elicitation. He does this by producing a third part assessment: “you’re a nice simple one” (line 6) following the patient’s (preferred) question response in line 5 (“no”). The norm encoded in ‘no problem’ preferring final concern elicitations is treated as implying that a ‘good’ consultation is sufficiently thorough that no further questions could remain at this point. In this way a ‘no questions’ response may project a judgment of ‘good care’, where the consultation is conducted with sufficient thoroughness and sensitivity to the patient’s needs that a ‘no questions’ assumption can relevantly underpin this final question. This joking response can also be understood as orienting to the normative interactional order where patients comply with the medical agenda. At this point in the consultation the doctor’s agenda is aligned with an optimized ‘no problem’ responses to final concern elicitations. This preference is encoded in the no-preferring design of such questions as that in Extract 50 (line 110). The doctor does not mark this as a delicate matter. He doesn’t smile making the assessment, maintains mutual gaze with the patient except for momentarily looking to his hands as
he makes an open, two-handed gesture coinciding with ‘nice’ (line 6), before returning his gaze to the patient for “simple one”.

The patient’s addition of “very easy” treats as relevant the dimension of what might be convenient for the doctor, namely that the doctor may prefer to have (and is willing to implicitly pressure the patient to provide) straightforward, uncomplicated, ‘easy’ work caring for patients. An aspect of the asymmetry that characterizes the doctor-patient relationship is that the doctor’s personal feelings or attitudes are not made relevant in the consultation. This is therefore an area that participants normatively treat as being off-limits. It is consequently the patient who explicitly orient to the notion of the patient (her) being ‘easy’ to look after and thereby being a favoured type of patient.

The doctor closes the activity with mutual gaze accompanied by multiple head nods (line 8) and he subsequently initiates a sequence of pleasantries that involve laughter and joking (lines 10-31).

**Extract 51  Final concern elicitation (C47)**

```
1    P    Right
2    (.)
3    D    Any questions? ((MG))
4    (0.1)
5    P    No
6    D    You're a nice ((two-hand gesture, looks at hands)) simple one((mutual gaze restored))
7    P    Very easy
8    D    (0.1)((MG, repeated head nodding))
9    D    I see you've been writing on your banana
10   (.)
11   D    us that heh heh heh
12    P    Did you read what's on there?
13    D    Yeah
14   (.)
15    P    Get well soon my little pickle those
16    (.)
17    P    pickles are the best
18   (.)
19   (.)
```
Sometimes patients (as in Extract 52, C7) submit to the constraints of the doctors’ negatively valenced final concern elicitation question by producing a preferred ‘no problem’ response initially but subsequently override their prior compliance with the constraints of the question by producing an extended request for help with an unresolved concern. In undercutting her ‘no problem’ response to the doctor’s question by subsequently presenting an unresolved concern, the patient in C7 (Extract 52 below) orients to the structural norms associated with this part of the consultation but challenges them by asserting her own agenda anyway (line 7).

**Extract 52  Final concern elicitation (C7)**

1  D   Yeah
2   (.)
3  D   Any questions?
4   (0.1)
5  P   No
6   (.)
7  P   If I can get rid of this shaking I mean if there are tablets or something
8   (.)
9  P   I don't know
10  (.)
11  D   Well I
12  (.)
13  there
14  (0.1)
15  there are some tablets which can help

The doctor’s response at line 11 displays the dispreferred nature of this newly initiated discussion. His response is prefaced by the discourse marker “well”, that orients to 328
the turn itself (or the action it performs, namely part of a newly-initiated question sequence) being dispreferred or disaffiliative (Bolden, 2014). In this context, the doctor is being pressured by the patient to discuss a further issue at a point in the consultation when he wants to bring the encounter to a close. In effect, the patient successfully imposes her agenda of wanting the doctor to provide a solution for the problem concerning her over the agenda projected by the design of the doctor’s no-prefering final concern-eliciting question. However, the patient’s success in pursuing the prescription for tablets is only partial at this point, and the discussion continues for another 45 lines before the doctor agrees to arrange for the patient to be prescribed some tablets (Extract 53, C7).

**Extract 53**  Patient pursuing agenda for tablets (C7)

16   D   .)((looks away from P))
17   P   Yeah
18   P   who is Ricky?
19   D   Obviously decided not to put you on them at the moment
20   .)
21   D   if this doesn't go away though
22   .)
23   D   y'know in the coming weeks
24   .)
25   D   Ricky Foster
26   .)
27   P   the neurologist
28   .)
29   P   Oh yes
30   .)
31   D   I only met him because the (( ))
32   .)
33   D   she saw me shaking and she said I think the (( )) my doctor (( ))
34   .)
35   D   Yeh
36   .)
37   P   Yes
38   .)
39   D   that's okay ((reaches down to put hand on P arm))
40   .)
41   D   and if you need some follow-up with him that's okay
42   .)
43   D   if it doesn't settle down
44   .)
45   D   there are some medications
46   .)
The doctor’s agreement to prescribe tablets to address the symptoms distressing the patient may be understood as a means of bringing the consultation to a close while at least nominally providing the patient with a final chance to raise concerns. This has been documented in other medical settings and acts to project the doctor’s agenda of wanting to bring the consultation to a close by discouraging the introduction of a new topic by the patient (Heritage & Robinson, 2011).

It is consequently not surprising that the patients usually comply with doctors’ negatively valenced final concern elicitations. This displays patients’ acquiescence to the terms of the questions at this stage of the consultation and in the context of a clearly understood impending termination of the consultation, possibly either because they have no further concerns to raise or because they feel constrained from raising them in a closing relevant environment where question design shows that a ‘no problem’ response is clearly preferred.

When new concerns are raised, or issues discussed earlier are reintroduced, it is not always patients who raise them; doctors sometimes introduce previously unmentioned mentionables (e.g. overlooked matters) to address before closing the consultation, (e.g. Extract 59 (C24)). As mentioned above, sometimes a new episode of history taking follows a patient’s question or arises from a summarizing discussion of symptoms among the medical team in the process of their preparations for winding up the consultation.
It is common for the consultation to end because there is nothing more to talk about (when the patient responds negatively to the doctor’s question: “Is there anything else?” or similar). Occasionally the patient accepts the doctor’s invitation to introduce a new concern or other topic of conversation at the end of the consultation. The doctor’s offer for the patient to discuss unresolved concerns is also rare but less so than a patient’s acceptance of the invitation (26%, n = 12/46). This possible pre-closing move also occurs in the core of many consultations.

When patients accept an offer from the doctor to say ‘something more’ it is often to reiterate earlier stated concerns to confirm or ascertain information about arrangements and in one atypical case where a patient initiates an opening-type greeting and introduction sequence, possibly as an elaborate farewell sequence that she later positions as a ‘show for the camera’ with the sequence (Extract 54, (C17) below):

**Extract 54  Patient saying something more at the consultation end (C17)**

3     we'll see you again tomorrow
4     P  Thanks (consultant's first name)
5           (0.1)
6     how are you (D2's first name)
7     D2  Good thank you
8           (.)
9     how are you
10    P   Registrar's name) how are you?
11    D1  Not too bad thank you
12    P   And these are two students?
13    D   (Students' first names)
14    P   (Students' first names).
15           (.)
16  I'm (patient's first name)
17             (.0.2)
18     heh heh heh and I'm very lucky to be looked after by these
19     D   wonderful doctors aren't I
20    D   See you tomorrow
21    P   Alright I'll be here=
22    D   Heh heh
23    P   Thanks
### 7.3.1.4 Making, summarizing and/or reiterating arrangements

Participants continue to orient to the interactional authority of the leading doctor to direct the consultation when arrangements are being made and negotiated, as is the case at most other parts of the consultation. Doctors typically initiate arrangement-making at the bedside, as has been reported in other medical settings (Heath, 1986; White et al., 1994; West, 2006), and patients are usually quite passive participants in this part of the conversation, providing confirmation of having heard and understood the arrangements outlined by the doctor, such as occurs in Extract 55 (C6) below. Joan is the doctor who is rostered on duty to lead the medical team for the following morning:

**Extract 55 Making arrangements (C6)**

1 D So Joan will see ya tomorrow morning
2 P Good
3 D So
4 (.)
5 home tomorrow if you’re well
6 (.)
7 P [Right]
8 D [And ] then an appointment to come back and see us over
9 road
10 P Right
11 (.)
12 good thanks
13 D Right

In common with these earlier findings, making arrangements is a very frequent, almost invariable component of the pre-closing phase of the bedside consultation. Overall, talk about arrangements occurs in 80% of bedside consultation closings in this study, either introducing new arrangements, for example about discharge planning, or restating earlier discussed arrangements such as the agreed proposed course of treatment or forthcoming tests or other pending steps in assessing how best to resolve the current medical or other issues relevant to the patient.

Table 7-3 below adapts White’s (2011) summary of components of arrangement making in the closing of surgeons’ consultations to show how arrangement making at the bedside is achieved. It shows that while there is some overlap in the issues that come up and are dealt with during arrangement making at the bedside and during
surgeon’s consultations, as described by White, there are a number of distinctive features of this activity in this previously undocumented context (i.e. the hospital bedside). This information is shown in Table 7-3, with the issues that only arise at the bedside shown in bold text.

Table 7-3  Components of arrangement making during pre-closing at the bedside

<table>
<thead>
<tr>
<th>Activity</th>
<th>Bedside consultations containing this activity (%)</th>
<th>n = 46</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arranging surgery</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Referring back</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Referring on</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Arranging diagnostic testing</td>
<td>15</td>
<td></td>
</tr>
<tr>
<td>Organizing follow-up</td>
<td>15</td>
<td></td>
</tr>
<tr>
<td>Paperwork instructions</td>
<td>7</td>
<td></td>
</tr>
<tr>
<td>Arranging discharge *</td>
<td>27</td>
<td></td>
</tr>
<tr>
<td>Doctor offer of future accessibility (e.g. “ring me on the mobile if you have concerns before our appointment next week”)</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>(Re-) affirming treatment plan</td>
<td>24</td>
<td></td>
</tr>
<tr>
<td>Referring to pending test results</td>
<td>11</td>
<td></td>
</tr>
<tr>
<td>Referring to follow-up</td>
<td>35</td>
<td></td>
</tr>
<tr>
<td>‘See you tomorrow’/at a particular later time</td>
<td>39</td>
<td></td>
</tr>
<tr>
<td>Organizing the removal of medical appliances e.g. bungs</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Promise of administrative follow-up on patient’s behalf</td>
<td>9</td>
<td></td>
</tr>
<tr>
<td>Patient requesting information or confirmation about arrangements</td>
<td>15</td>
<td></td>
</tr>
<tr>
<td>Activity</td>
<td>Bedside consultations containing this activity (%)</td>
<td>n = 46</td>
</tr>
<tr>
<td>----------------------------------------</td>
<td>---------------------------------------------------</td>
<td>--------</td>
</tr>
<tr>
<td>Patient reiteration of earlier request</td>
<td>9</td>
<td></td>
</tr>
</tbody>
</table>

Table based on White (2011)

Discharge discussions are described in Chapter 6 because this work is recurrently treated as part of the core business of the consultation. However, reference to discharge arrangements also commonly occur as part of the pre-closing activities of the consultation, which is why it is included in Table 7-3 above.

The components of arrangement making at the bedside form a distinctive pattern that differs from that described as occurring in consultations with surgeons in specialist clinics in a community setting by White (2011). Although White does not provide frequency counts for the occurrence of the different activities observed in the surgeon consultations in her data, the categories alone show that the nature of the participants’ concerns in medical consultations with surgeons differs markedly from those reflected in the activities occurring at the hospital bedside.

There is a small overlap between the categories of activity White (2011) describes as occurring in arrangement making during surgeon visits and those that occur during bedside consultations. These activities include arranging diagnostic testing, organizing follow-up, and giving instructions about paperwork that the patient will need to complete for some consultation-related reason (e.g. paying for the consultation with the surgeon, organizing forthcoming follow-up or unscheduled appointments for the inpatient). However, many of the activity categories White highlights do not overlap with activities involved in making arrangements at the bedside. In fact, there are more of these than of those that do overlap, representing a substantial difference in the relevant arrangement making activities in the two settings. Arranging surgery, referring back and referring on do not occur during the making of arrangements during closings of bedside consultations in this study. This suggests that these activities are not relevant to participants during this task in this setting.
In addition to this, eight types of activity occur during the making of arrangements during the closing of bedside consultations that are not mentioned in White’s account of arrangement making during the close of surgeon visits. These are: arranging discharge, reaffirming treatment plan, referring to follow-up (that had already been arranged), referring to (previously arranged) pending test results, promises to “See you tomorrow” or at a particular later, offers by the doctor of future accessibility (e.g. by asking the patient to call on the mobile phone if they have concerns before a scheduled follow-up appointment), organizing the removal of medical appliances (e.g. bungs), and promise of administrative follow-up on the patient’s behalf (e.g. in trying to arrange for the patient to be moved to a different room).

Many of the activities that feature in arrangement making during the closing of bedside consultations are not relevant in an outpatient setting and deal with particular issues that are current in an inpatient hospital setting. They have been documented for the first time in this study and are uniquely distinctive to arrangement-making at the bedside in particular, and to the process of managing closings in this setting in general. Activities such as doctors’ offers of future accessibility, references to already arranged follow-up and undertakings to “see you tomorrow” or at some particular later time all convey implicit or overt assurances of continuity of care either within the hospital while the patient remains resident there, or after the patient has left the hospital. Continuity of care is a very important component of medical care in any setting, but it is particularly important where patients have been hospitalized. There are several reasons for this. They include the fact that many hospital inpatients are vulnerable either temporarilily or in the longer term because of their illnesses and associated frailty that may or may not be temporary, and because of the fear, anxiety, incapacity and confusion that may be a part of this experience. The patient may also experience a sense of alienation as a resident of a large and potentially seemingly impersonal institution (the hospital), which may be noisy, busy and operating according to routines and rules the patient may have trouble understanding or feeling comfortable with. These issues and those addressed below are also likely to be important reasons for the prominence of these arrangement-making actions.
Conversely, patients may feel daunted and uncertain or apprehensive at the prospect of discharge from the hospital, which may represent safety and the security (or comfort) of having 24-hour medical help available if needed and the tasks of daily living attended to so that the patient could rest. In this situation, the doctor may wish to provide encouragement and reassurance to the patient that when they leave the care of the hospital, they will not be alone or lose access to expert and relevant medical care and advice. Offers to make administrative representations on the patient’s behalf may provide the patient with reassurance that their requests for change may be heard and responded to positively (e.g. to change to a quieter room) with the advocacy of a senior member of the organizational hierarchy onside. References by doctors to pending test results, follow-up and reaffirmation of treatment plans help remind and reassure patients of forward movement in their care, and of the nature of those plans.

Finally, as indicated in previous chapters, discharge planning is a characteristic feature of the inpatient arrangement making process, as it is the aim of hospital treatment to restore the maximum number of patients to health and independent living as quickly as possible. The discharge from hospital is consequently one of the key objectives of inpatient medical care. It is also a feature of the context of the bedside consultation that is unique and distinctive to this setting in comparison to other contexts in which medical consultations have been documented.

Most closings at the bedside - 67% (n = 31/46) - contain some kind of discussion about future arrangements, of which the majority involve outlining new arrangements (35/46 = 76%) and around a quarter (11/46 = 24%) involve re-invoking previously agreed arrangements. Arrangement-making during the consultation pre-closing section is usually initiated by the doctor (84% or 26/31), with 13% (4/31) initiated by the patient and 3% (1/31) by a nurse.

Bedside consultations are never closed by means of the doctor explicitly citing his or her medical responsibility to other patients as a reason for winding up (for example, in West, (2006:393): D: “Okay. The time is getting late (an u:h), (.) I: have o:ther things tuh do a:n’ (.) as well as you:) At the bedside there are none of these, except for the response to a patient’s attempt at humour, (which could serve as a ‘deviant case’)
In this example, the reference to general or other doctoring needs superseding the needs of this particular patient, is in response to the patient’s joke. It is not an example of the doctor using the medical or other demands of doctoring as a reason for closing the visit, although the doctor’s response has this effect. It is also an example of a po-faced response to a tease (Drew, 1987).

7.3.2 Final closing

Activities that recurrently occur in the closing section of bedside consultations are described and discussed in this section. They are thank-you sequences (§7.3.2.1), pleasantries (§7.3.2.2), farewells/terminal sequences (§7.3.2.3) and breaking co-presence (§7.3.2.4).

We can gain insight into patterns in how participants work together to bring consultations to a final close by looking at what activities they recurrently construct and combine to achieve this, as well as who (doctor or patient) initiates the various final closing activities. The frequency of these the final closing activities that precede the breaking of physical co-presence, as well as the frequency with which different categories of participants initiate each activity, is summarized in Table 7-4 below. The frequency of different combinations of these final closing activities shown in Table 7-5.

<table>
<thead>
<tr>
<th>Activity</th>
<th>Frequency (%)</th>
<th>Doctor initiated (%)</th>
<th>Patient initiated (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Thank-you sequences</td>
<td>87</td>
<td>2</td>
<td>98</td>
</tr>
<tr>
<td>Terminal exchange (leave-taking sequences)</td>
<td>70</td>
<td>74</td>
<td>26</td>
</tr>
<tr>
<td>Pleasantry</td>
<td>52</td>
<td>50</td>
<td>50</td>
</tr>
</tbody>
</table>

Table 7-4 shows that the final closing most consultations are characterized by thank-you sequences, the vast majority of which are initiated by the patient. Pleasantries
occur less often but are still quite common, being exchanged during around half of all final consultation closings. However, unlike thank you sequences, pleasantries are equally likely to be initiated by doctor as patient. Conversely, terminal leave-taking sequences are usually initiated by doctors, which makes sense given the fact that it is invariably the doctor who breaks co-presence at the completion of the encounter by leaving the consultation space.

All (100%) the consultations in this data end with an eventual breaking of co-presence, and in addition, all consultations finish with at least one of the other three activities – thank you sequences, pleasantries and farewells/terminal sequences – and sometimes with a combination of several.

These actions are invariably accompanied by smiling, changes in body posture or positioning including (the doctor) leaving the consultation, or gestures such as waving or hand shaking, deployed by either party, particularly the patient. The following section reports how doctors and patients manage the final seconds of the consultation closing at the hospital bedside.

Consultation participants co-construct terminal sequences during the consultation’s final closing section using resources drawn largely from practices used in mundane conversation.

Terminal (or leave-taking) exchanges are very common (although not invariably present and less frequent than thank-you sequences) and doctors usually initiate the activity of the terminal exchange sequence. Terminal exchanges occur in 70% of consultations and are discussed in more detail in §7.3.2.3. The activity of pleasantries (or ‘small talk’) is less common than either terminal sequences or thank you sequences, but they nevertheless occur more than half the time (52%) and are equally likely to be initiated by patient or doctor. The activity of pleasantries is discussed in more detail in §7.3.2.2.
7.3.2.1 Thank-you sequences

Doctors and patients (and others) in the bedside consultation orient to ‘thank you’ sequences as being a relevant closing activity. Quantitative evidence of their prevalence across the data set is shown in Table 7-4. The thank you sequence is the most frequent activity to act as a prelude to the terminal sequence at the bedside. It occurs in 87% (n = 40/46) of consultations, with patients overwhelmingly being the participants most likely to initiate it.

Both doctors and patients orient to patients being the relevant parties to initiate the activity of thank-yous through a thanks sequence, and to express gratitude to doctors at this point in the consultation. The evidence for this is that patients almost invariably initiate thank-you sequences, with only very rare exceptions when the doctor thanks the patient.

The fact that patients almost invariably thank doctors emphasizes the institutional context of the interaction by invoking the beneficiary/provider relationship between them and seeming “to formulate the visit as a service encounter rather than a visit among friends” (West, 2006:390). West (2006:398) suggests, with reference to the primary care context, that doctors may act to prompt thanks by patients through making arrangements, that thereby implicitly highlights the nature of the (epistemically and emotionally asymmetrical) relationship between them as well as moving the consultation towards completion.

Alternatively, the institutional relationship between doctor and patient is not only reminiscent of a (service) provider/(client or) beneficiary as mentioned above, but it imposes role-related responsibilities that for the doctor include making discharge and post-discharge arrangements. In an institutional relationship, thanks are probably optional for the client/service recipient, and where thanks are given, the relevance of reciprocal acknowledgments (e.g, ‘it’s a pleasure’, ‘you’re welcome’ etc) may be waived.

However, it is possible in this context that doctors orient to institutional norms regarding thanks outlined above (i.e. where service provision is intrinsic to their roles,
that thanks for those services are not relevant, and efficient task completion is a priority) while patients orient to the norms of mundane social contexts where thanks for favours or gifts are relevant. This could explain the situation here where patients routinely thank doctors as consultations close, but doctors seldom acknowledge their thanks.

Sometimes, the patient’s first part thanks is reciprocated (C46) P: “thank you very much”/D: “it was a pleasure looking after you again”.

It is noteworthy however, that second part acknowledgments are quite often withheld from thank-you sequences. For example (Extract 56, C44):

Extract 56  Thank-you sequences (C44)

1  P  Thanks very much
2  D  Bye bye
3  P  Bye

Alternatively, when a second part is produced, it is often not a matching second part (e.g. ‘it’s a pleasure’) but is rather: D: “see you” (C7), “see you later” (C4). Another example of a non-fitted second part to a thank you is (C30) P: “thank you”/D: “don’t get sunburnt!” In this final example, the doctor’s light-hearted instruction to the patient appears to act as a transition from institutional to conversational, mundane interactional mode, perhaps as a means of reinforcing its sequence closing function.

Occasionally the doctor initiates a thank-you sequence, when the patient usually produces a fitted second part, as in C23: D: “thank you”/P: “thank you doctor”.

Quite frequently, several thank-you sequences occur before a transition is made to the next activity, which is usually the terminal sequence (See §7.2.2.3). This appears to show participants orienting to the thanks sequence being a stand-alone statement rather than a sequence, because on a number of occasions, patients repeatedly produce ‘first part’ thanks, which are reciprocated or acknowledged in some way (that is usually not
fitted) by the doctor, until the ‘first part’ is ignored and the ‘second part’ withheld. Instead, in these cases the consultation makes a transition into the next activity, that is usually the final or terminal sequence, which is unusual in that they do not project or make relevant further response from the patient (or anyone else). This pattern is unlike what has been reported in other consultation settings, and it may show the patient repeatedly trying to elicit a fitted response to their FPP thanks, or alternatively (given the absence of fitted SPP), misalignment between doctor and patient in understanding of the action being performed by the thanks.

This observation that patients appear to orient in this way (i.e. by continuing to initiate thanks until they are ignored by the doctor) to the relevance of their thanks not being responded to by the doctor may suggest that thanks fulfill the function of anticipating a termination of the consultation in a similar way that arrangement-making can be used to elicit thanks (West, 2006). It may be that participants orient to thanks by patients to doctors being relevant in a similar way that terminations should follow thanks. This dynamic may also be relevant in other clinical and mundane settings. However, it could also display the distinctive level of dependency and vulnerability of inpatients. This is unique to the bedside consultation and may be emphasised by the strongly 'homelike' mundane character of the consultation space as 'home' to the patient.

Alternatively, it may be that doctors withhold termination sequences until the patient provides thanks to which the doctor does not feel it is relevant to reply. Either way, it appears that participants may orient to an overall structural organization for the consultation closing whereby thanks are followed by terminal sequences, and terminal sequences are preceded by thanks. Furthermore, patients should thank doctors, but doctors need not ratify thanks and in addition (or instead) they can initiate terminal sequences.

In these ways, considering West’s (2006) observation, participants orient to a transactional relationship as much as a ‘caring’ relationship, the consultation being a service encounter where the recipient of the service is the patient, and the service provider is the doctor.
Most bedside consultations in this study are brought to a close with thanks sequences initiated by the patient, usually followed by terminal sequences. Almost all closings have either a terminal exchange or a “thank you” or both (43/46 = 93%). Thanks exchanges characterize the closing of institutional and in particular service encounters, and at the bedside this aspect of the relationship between doctor and patient appears to be highlighted in this way. 85% (39/46) of bedside consultation closings in this study have “thank-yous” and 37% (17/46) have terminal sequences of some kind.

7.3.2.2 Pleasantries

Pleasantries (or ‘small talk’), such as (C5): D: ‘see you tomorrow’ P: “...be good you lot’ D: ‘oh they won’t’) are common features of termination sequences at the bedside, occurring in just over half of consultations. They play a similar role regardless of who initiates them, and pleasantries appeared to be taken as conveying a sense of solidarity and shared experience between participants, and recipients respond in a similar vein. Pleasantries are often lighthearted or joking comments such as can be seen in Extract 57 (C1):

**Extract 57 Pleasantries (C1)**

1  P  So I should get dressed and
2  D  Um give
3   (.)
4  D  the nurses some time to do the paperwork
5   (.)
6  D  otherwise they might get a bit agitated
7  P  They might

Or Extract 58 (C9) - this patient has been directed to walk as much as possible:
Participants orient to the relevance of either doctors or patients being initiators of pleasantries during the consultation closing, and the distribution between the two is approximately even. Regardless of who initiates the pleasantry, recipients produce confirming responses that signal their understanding of the previous turn as a pleasantry. This contrasts with the lack of reciprocation in response to patient initiations of thanks. It is evident in the two examples above (Extracts 57 and 58), one initiated by the doctor, one by the patient (from C1 and C9). Both recipients clearly signal their understanding that a lighthearted comment has just been made. This shows that both parties often display good will to each other as a final gesture when closing the consultation. There are a number of possible explanations for this pattern. For patients, expressing pleasantries may be a way of signaling troubles resistance (Jefferson, 1974) in the face of a situation that may be uncertain, frightening and/or seemingly undignified. Pleasantries may be for them a resource for dealing with the delicate situation of the patient who is publicly enfeebled as a hospital inpatient. For doctors, pleasantries may offer a way of showing concern for and solidarity with their patients, and in this way a wish to implicitly reassure patients that they can rely on responsive continuity of care.

In addition, the expression of pleasantries may reflect for both parties a strategic orientation to politeness norms in dealing with people who are not well known, thereby minimizing or attempting to undercut the institutional character of the interaction conveyed in the expression of thanks (discussed above). Pleasantries may comprise jokes, which have been shown in primary care contexts to be drawn upon by patients to manage delicate or embarrassing situations (Jefferson, 1974; Haakana, 2001), or they may be well wishes, wry commentary on some aspect of the
hospital routine or the experience of illness or enfeeblement, delivered as friendly asides, or ‘small talk’.

7.3.2.3 Farewells: Terminal sequences

Closing follows and results from the termination jointly achieved by doctor and patient of the transition rule whereby ‘speaker change recurs or occurs’ through conversation (Sacks et al., 1974:271). For termination of the consultation to occur, this rule must be suspended. The point where this occurs varies, so that one or more of a number of late, potentially final, apparently terminal sequences are used to perform this action. Such potential final actions include thanks, pleasantries and leave-taking sequences. The pattern of activities found in terminal sequences in this data are shown below in Table 7-5.

Terminal sequences may consist of complete, incomplete or expanded farewell sequences. Terminal exchanges can be treated as being complete where a leave-taking adjacency pair occurs with adjacent (or almost adjacent) first- and second-pair parts produced by doctor and patient. This happens slightly more often (43%) than when only a single pair part is uttered (33%) on its own or in combination with some other closing action.

Sometimes ‘complete’ terminal exchanges (where adjacent first and second pair parts are produced) are not lexically matching but the action of the pair is to terminate the conversation. For example (C6): D: “See ya”/P: “good bye”. Some terminal exchanges are expanded with inserts such as a stand-alone thanks (C1) D: “bye bye now”/P: “thank you (.) bye bye”. Doctors initiate terminal sequences more often than patients do (70% compared to 30%). No parallel data is available for comparison from studies of who initiates terminal sequences in other clinical settings, but the predominance of the doctor as initiator of the final consultation closing at the bedside is consistent with the doctor’s role as initiator and driver of other aspects of the consultation. This is also consistent, however, with the normative practice in mundane interaction where farewell sequences are initiated by would-be departing parties.
Incomplete terminal sequences, for example where there is no terminal utterance by an addressed patient (which could be taken as an accountable absence), are not uncommon at the bedside. In the absence of more information, it may be that incomplete terminal sequences occur more frequently at the bedside than they do in a primary care or other medical settings as a reflection of the routine nature of the daily ward round. This may be a pattern that displays some distinctive aspect of leave-taking in this setting that is not relevant in other clinical environments.

A possible alternative explanation for some instances where terminal utterances are incomplete is that the second (AP) part may be delivered nonverbally, for example by means of waving and smiling (C5, C13, C25) and/or nodding (C40, C41, C45) so that on a transcript of spoken utterances there appears to be no response where in fact a response is provided using embodied resources. In all these cases, where only the first part of the terminal sequence is voiced, it is the doctor who delivers the ‘stranded’ first part, and the patient who acknowledges this first part, nonverbally, by nodding or smiling. In each of these cases, the doctor turns to leave immediately the first part of the farewell sequence has been uttered, often waving and smiling as they do. Doctors may deploy these affiliatory embodied resources to soften the potentially face-threatening action of terminating the consultation.

The patient signals understanding that a response is relevant to complete the terminal sequence but, in these cases, produces nonverbal second parts. The reason for this sequence pattern is unclear, but the doctor’s hasty departure from the interaction space following a multimodal first part termination turn, may convey a downgraded (or changed) expectation of how the patient should respond or whether they should respond. The nonverbal action of the doctor turning his or her back on the patient may be the signal for this changed expectation. The patient may recognize that a responsive second part is relevant, but that its form may be expected to be different (e.g. nonverbal/embodied). As a result, the patient produces the second part nonverbally, thereby completing the terminal sequence.

Farewells or leave-taking occur as adjacency pairs, when they consist of such pairs as “bye”/“bye”, “good bye”/“good bye”. In over a third of occasions
(33%, n = 15/46) when there is a terminal sequence or a part thereof, farewells remain un-responded to, such as when a doctor utters a farewell such as “see ya” (C40, C46, C47, C48) and then leaves the consultation space immediately afterwards. The classification of leave-taking as a terminal sequence seems to overlap at times with pleasantries, when utterances (invariably made by doctors) are produced that may be taken as and responded to as the first part of a terminal sequence but may also be taken as statements to which response is optional. They are usually produced as the doctor leaves and include: “nice to see you again” (C25), “all the best” (C32, C41), or more neutral “see you later” (), “we’ll leave you to it” (C45), “have a good week then” (C49), “see you then” (C49).

Table 7-5 Configurations of terminal sequences in bedside consultation closings

<table>
<thead>
<tr>
<th>Action</th>
<th>Number of occurrences (total n = 46)</th>
<th>Percentage of consultations (n = 46*)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Thank you only</td>
<td>4</td>
<td>7</td>
</tr>
<tr>
<td>Terminal exchange (complete or partial) only</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Pleasantries only</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>No terminal action</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Thank you + terminal exchange</td>
<td>16</td>
<td>37</td>
</tr>
<tr>
<td>Thank you + pleasantries</td>
<td>8</td>
<td>13</td>
</tr>
<tr>
<td>Terminal exchange + pleasantries</td>
<td>4</td>
<td>8</td>
</tr>
<tr>
<td>Thank you + terminal exchange + pleasantries</td>
<td>10</td>
<td>27</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>46</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

* Closing data were not recorded for two consultations for technical reasons.

No consultation finishes without some kind of action other than breaking co-presence, that is oriented to by participants as a recognizable termination sequence or marker. This shows that an official end point in addition to or in conjunction with the breaking of co-presence is an essential component of the bedside consultation. Further evidence supporting the notion that an official end point is a necessary part of a properly
constituted consultation is seen in this data when a consultation fails to fulfill this requirement, for example if it restarts after an earlier closing (as in Extract 59, C24 below).

Sometimes a consultation that has already been completed is re-opened or re-started by either the doctor or the patient (in 22% or 11/48 of consultations). When patients restart the consultation after it has closed, it is most often to clarify arrangements (3/6 or 50% patient restarts), or less often to contribute a pleasantry (2/6, 33% patient restarts) and occasionally – on a single occasion (1/6 or 17% patient restarts) to play to the camera by initiating a howareyou sequence (in the consultation where the patient offers the doctor hospitality during the consultation opening, which the doctor refuses, see Extract 20 and Figure 15).

Where a doctor restarts the consultation, having previously wound it up, he or she may have left the consultation space, then return to reiterate arrangements, contribute pleasantries and occasionally to resume history taking to resolve previously unresolved issues (as in Extract 59 below, from C24). Alternatively, the doctor may delay leaving in order to be able to make additional points. An example of the first situation is illustrated in Extract 59 below, where, at the end of the consultation closing the doctor reinstates the consultation using self-initiated repair, using a change of state marker ‘oh’ as a repair marker at the point where she recognizes that there has been an erroneously omitted item of business that must be addressed before the consultation finishes. The doctor’s turn in line 136 can be understood as self-initiated self-repair, because the doctor signals that there is an overlooked item of business requiring mention. This means that the consultation must be re-started, despite having been wrapped up in line 134, when the doctor leaves the consultation space and the patient (in line 135) thanks her.

**Extract 59  Re-starting the closing after termination (C24)**

2 D  So I’ll speak to you this afternoon ((doctor looks at patient then, turns head & leaves interaction space))
3 P  Thank you ((doctor turns and walks away to join medical team reading patient records; junior doctor points to screen))
4 D  Oh: (.)
5
6
7
okay ((turning to face patient, body still angled out of space, to records))
and I forgot to ask you
(.) ((D maintains position and with 'how', walks back into interaction space, making iconic hand-to-hip gesture synchronous with question, repeated with verbal repetition))
how is your how’s your um how’s your hip?
[(after your injection? )]
P [I got an injection yesterday]
D Yeah?= ((nods head once again))
P I said I could have gone to the Olympics
(0.1)
D Is it better?
P Oh yes (.)
D so far
P Let let’s have a look. ((deictic pointing towards P, moves towards P))
D I got some business on there
(.)
look
(.) ((P moves forward to sitting to allow examination, D moves forward))
and I’ve got your name on there
(.)
((turns to put paper on tray, D & P both turn to look at paper))
because I seem to forget
(0.5)
(.)
oh
(0.8) ((D & P both resume earlier 'examination positions'))
so the pain’s gone away?= ((D looks at P synchronous with semantic/phonological peak of utterance))
P No it's just it’s just
(0.3)
((MG, sagittal head shake, repeated metaphoric hand gesture)) very light.
(.)
you know?
(.) ((D looks down at hip))
(.) [Nice and] like a crepe y’know?
D [Okay ]
((MG, smiles, turns & starts leaving space; P looks at the D, smiles & waves))
P Excellent!]
(.) ((turns and walks out of space))
D Okay

In this example of a consultation re-start, the doctor had left the space to discuss matters arising from the just completed consultation, and subsequently turned and then re-orientates her head, then her body, back towards the patient in the consultation space and re-enters it, reinstating the consultation. In doing so, the doctor enacts a sequence of self-repair, signaling to the patient that she realizes she has forgotten to
mention a particular mentionable item. This action is treated as accountable by the patient, who turns her head and gaze back towards the doctor, quickly raises her shoulders, and her face momentarily assumes a surprised expression with wide-open eyes and raised eyebrows in response to the unexpected re-start.

Structurally, this excerpt consists of several sections: a closing section, a repair segment and two related question sequences. Participants manage the transitions between sequences using strategically chosen discourse markers. The first closing sequence is introduced by “so” (line 134) that projects the focus of the talk to future arrangements (D: “I’ll speak to you this afternoon”). This is followed by the patient’s signal of understanding and acceptance of the plan and of the closure of the present consultation that the plans imply. The patient gives a sequence-closing assessment (P: “good”) followed by thanks, whereupon the doctor signals disengagement verbally and physically, and leaves the space.

During the subsequent consideration of the patient’s records by the medical team, a realization occurs of an oversight – a previously unmentioned mentionable – the patient’s hip. The doctor signals this development with the discontinuity marker “oh”, followed by a sequence-closing assessment and transition marker “okay”. The doctor then enacts the transition by turning back to the patient, initially only turning her head, gaze and upper body back towards the patient as she begins the pre-sequence, beginning “and I forgot to ask you”. There is a brief pause while the doctor establishes mutual gaze and thereby confirmation that she has the patient’s attention again. Once this occurs, the doctor moves back into the space and begins the first history-taking question sequence regarding the patient’s hip.

The patient provides a metaphorical response to what Fox & Thompson (2010) term the ‘telling-eliciting’ wh- (content) question “How’s your hip?”. This lacks the detail sought by the doctor who follows up with a yes-preferring, confirmation-seeking polar question accompanied by an eyebrow flash (“is it better?”). The patient’s response (“oh yes (. ) so far”) is qualified by discontinuity marker “oh”, a brief delay and then a qualified confirmation “so far”. This
response conveys reluctance to confidently endorse the assertion that the hip is fully recovered (despite her early announcement that “I could have gone to the Olympics”), and this reluctant response prompts the doctor to propose a physical examination.

The physical examination begins after some brief preliminaries, accompanied by another yes-preferring polar question, this time formatted with the even more strongly yes-preferring declarative design (“the pain’s gone away?”), prefaced by forward-projecting, other attentive “so”. The semantic and prosodic peak of this question (“gone away?”) was accompanied by the doctor’s gazing at the patient, as she rubs the area of the patient’s hip she is examining, watching for a physical pain response as well as attending to the patient’s spoken assessment of the pain. The patient’s response, describing a small amount of pain (“very light”) is sufficient in detail and content for the doctor to then close the examination with first a sequence-closing assessment (“okay”) that is accompanied by mutual gaze and head-nodding. This is followed by a second sequence-closing assessment that is upgraded both in terms of lexical choice (“excellent”) and embodied action (smiling, followed by walking out of the space).

This brief episode of history-taking and physical examination concludes when the doctor makes a topic-bounding assessment (“excellent”) followed by a pre-closing initiating “okay” (line 136). This example illustrates how a first consultation closing can be overridden and the consultation resumed if a previously unmentioned or unresolved issue is discovered. In other words, closing cannot be successfully achieved until participants reach the point where all items of business they regard as important have been dealt with and disengagement has been achieved. In this case the second closure of the consultation is brief, and straightforwardly achieved with the doctor’s departure and the patient’s sequence closing discontinuity marker “okay”, smile and wave to the doctor. The final closing of the consultation then follows, comprising thanks from the patient, a complete terminal exchange and pleasantries.
This excerpt also illustrates how participants coordinate different communicative resources to accomplish a stepwise disengagement of attention during the consultation closing. This process of disengagement during the consultation closing sometimes involves a degree of back-tracking. Here, the sequences through which the doctor performs her initial departure and then the reinstates physical and verbal examination of the patient are accomplished using embodied means as well as speech, as described in the transcript and analysis above. Gaze, hand gesture, proxemics (occupation of the interaction space) and facial expression are all synchronously deployed with speech, as the doctor investigates the patient’s hip pain, and makes an assessment of it on the basis of the examination and on the patient’s responses to her questions.

The doctor uses gaze and facial expression as well as posture and hand action to show what stage in her investigation she is at. The doctor uses these means to signal when she is investigating and wanting to elicit more information and when she has gathered enough information to reach a sufficiently firm assessment to be able to leave and wind the examination (and closing) up. This final closure is also achieved in a communicatively composite way, with mutual gaze being broken and the embodied signals of engagement (such as bodies oriented towards each other and positioned close together) stopped, and embodied signals of disengagement being activated (such as walking away, speaking to others and ignoring the patient).

The patient signals her understanding and acceptance of the breaking of engagement that is necessary to end the consultation by looking at the doctor as and after she leaves the consultation space, smiling and waving as the doctors leave.

7.4 Summary and next chapter

In this chapter, the process by which participants in the bedside consultation brought their encounter to a close is described in terms of activities that characterize the closing in this study data. The discussion shows that despite the variations between individual consultations and the iterative character of the consultation, participants orient to a normative overall organizational structure for the closing. The following activities characterize the consultation close and are oriented to as normative by participants:
final concern elicitation, making, summarizing and/or reiterating arrangements for next steps (including the details of discharge from hospital and follow-up visits in the clinic post discharge), thank-you sequences, pleasantries, farewells and breaking co-presence.

In general, participants orient to the doctor as having the right (and responsibility) to initiate most new activities through which they work towards disengagement during the consultation closing. The chief exceptions to this ‘rule’ of orientation are pleasantries (which are treated as being able to be relevantly initiated by either doctor or patient) and thanks, which are oriented to as being the responsibility of the patient to initiate. Indeed, in the case of thanks, participants often treat these as being relevantly ignored by recipients (chiefly doctors), and patients not infrequently repeat first pair part thanks until they receive no response from the doctor. In this way, the organization and conduct of the consultation closing reveals participants’ shared understanding of their respective interactional rights and responsibilities.

The brief discussion at the end of §7.3.2.3 regarding the design and interactional impact of questions and question design in the consultation closing provided another perspective on how doctors, chiefly, exercise their interactional authority to direct the interaction.

In addition, I presented a brief outline of patterns of participation evident in the consultation in terms of the distribution of turns between participants as well as the distribution of rights to initiate new activities. This perspective reinforces what is evident in the transcribed interaction, namely the clear orientation by all participants to an asymmetrical pattern of participation as well as allocation for managerial rights and responsibilities in the consultation between doctors and patients.

In the next chapter (Chapter 8) these results, as well as those reported in Chapters 5, 6 and 7 are summarized and discussed in the context of what we already know about the organization and conduct of medical consultations.
Chapter 8  Discussion and conclusions

8.1  Summary of findings

The hospital can be a place of extremes for those in it, be they workers, patients or visitors, and the experience of being involved in its work, life and routine can be correspondingly intense. Patients are admitted to hospital because they have health conditions or needs that cannot be managed in a community setting, whereas ancillary workers and medical staff – doctors, nurses and allied professionals - work in a complex environment sometimes charged with administrative, medical and emotional urgency. Hospitals are also places of learning and teaching for those preparing for careers in healthcare, particularly for work as doctors, and opportunities for such learning are often integrated into regular hospital activities (Ajawi & Rees, 2015).

Hospital routines exist to impose order, efficiency and calm on the work carried out in this environment, and a key component of the hospital routine is the daily ward round visit to inpatients by their doctors. Within the ward round visit is the bedside consultation where doctors see, speak to and examine their patients at or by the patient’s bedside. Questions about how the experience of performing the communicative work of the bedside consultation is for patients and other participants, how this work is managed by medical staff and how it can be be optimized or improved have only relatively recently begun to be asked by medical communication researchers.

This study is underpinned by the idea that what goes on in interaction between doctors and patients at the bedside provides glimpses of many of the issues mentioned above. It casts light on how this frequent and potentially high stakes consultation unfolds, how doctors organize and manage it (and that they do, predominantly, manage it), how patients act to be heard when they want or feel able to, and how they accept the interactional status quo; how junior doctors and medical students play their parts in the consultation and how their supervising doctors help them do so; how anxiety, embarrassment, loneliness and confusion are displayed and responded to by patients and doctors (and others), how sometimes intractable medical dilemmas are discussed by doctors and patients, and how interactional dilemmas are managed.
Much investigation of medical discourse focuses on such particular aspects of medical work as what is done during consultation (Urquhart, Ker & Rees, 2018; Beach & Dixson, 2001; Bolden & Angel, 2017) or how relationships between participants play out in interaction (Monrouxe, 2010), providing detailed insights into important and interesting issues. However, less research has taken a bigger picture structural approach, looking at participants’ orientation to the consultation as a whole event through its overall structural organization – “a large-scale structure of social action that organizes physician-patient interaction” (Robinson, 2003:454). This focus can provide a structural overview of a little-known consultation type (White, 2011) or act as a platform for investigating some component of consultation, such as patient participation (Robinson, 2003).

My study focused on the inner workings of the bedside consultation within the broader context of its overall organization as a basis for comparing it with other kinds of medical consultation. I looked at how participants worked together to enact and order the activities through which they talked about how things were going for the patient, what this meant and what came next. To do this, I shaped my investigation around the organizational structure of the bedside consultation at different levels – as a complete episode of interaction and as a collection of component parts (opening, core and closing).

I also looked at how on-the-job clinical training and professional socialization were accomplished for and by junior doctors and medical students through participation in the consultation. My investigation focused on a structural analysis of the videotaped data in order to describe the organization of the consultation and to gain an insight into the issues that participants dealt with during the bedside consultation through the activities they conducted. My motivations for this work were to describe something not previously extensively described, to investigate it for the sake of contributing to our knowledge about medical discourse per se, and also to uncover information and insights that could be useful in the provision of inpatient care through medical practice and clinical training and education in the inpatient setting.
Analysis of the consultations in the study confirms that the bedside consultation is sufficiently different from other kinds of previously described medical consultation to be considered a distinctive type of medical consultation in its own right (Sarangi, 2000). This is evident in the structural organization of the consultation, and this organization in turn reveals unique issues and imperatives that participants in these consultations need to address. In this chapter, findings from the results chapters are brought together to show how the bedside consultation is distinctive in terms of its organizational structure and activities, and how these structural features reveal the distinctive work that is done at the bedside.

The thesis presents a portrait of the bedside consultation that occurs as part of the daily ward round visit, based on videotaped recordings of a series of consultations that took place in an Australian hospital in 2010 and 2011. This portrait is ‘broad brush’, designed to give a sense of the particular character of this kind of consultation showing both its internal structural regularities and variation. The bedside consultation is complex, so this thesis focuses on describing its overall structural organization as a complete episode of interaction and also describing the organization and conduct of its component activities. Together, it is intended that these accounts provide a ‘big picture’ and smaller picture ‘portrait’ of the bedside consultation, together producing a conceptual framework within which to understand its work and conduct. Such a framework also provides the basis for comparisons with medical consultations in other settings previously investigated in a similar way (Byrne & Long, 1976; ten Have, 1998; Robinson, 2003; White, 2011). Examining the structural organization of an interaction can show how participants use interactional structures and practices to conduct work to be done and issues to be addressed and resolved. Space limitations prevent detailed analysis of every activity in the bedside consultation, many of which could be investigated further in future research. However, as this kind of medical consultation has been less thoroughly investigated than some others (Heritage & Maynard, 2006; Heritage & Stivers, 1999; Haakana, 2001; Robinson, 2003), an overall account of how it unfolds seems like an interesting and worthwhile place to start.
In producing a portrait, the question arises of what issues animate and are evident in the subject? In the case of the bedside consultation, this question takes the following (compound) form: this event that occurs during the daily morning ward round visit is frequent, and potentially high stakes for those involved, particularly the patient. What issues does it deal with overtly? Are there distinctive communicative challenges participants manage, and if so, what are they, how are they made evident and how are they managed?

The interactional complexity and administrative pressures of the hospital that have been documented in the context of the emergency department (Slade et al., 2008; Slade et al., 2015) and the hospital at large (Launer, 2010), turn out to be evident at the bedside.

As well as being a clinical event focused on providing medical care for sick patients, the bedside consultation is a workplace (Olmos-Vega et al., 2018), and somewhere that on-the-job clinical training occurs for medical trainees at different levels, so this constitutes an additional strand of work that is done at the bedside and adds to another distinctive feature of this kind of consultation, its complexity. Junior doctors and medical students have the opportunity to practice and receive supervision and feedback about their professional clinical skills from senior doctors. This is valuable, but may also be intimidating for them at times, (Scott et al., 2015) and for the supervising senior doctors, these teaching, supervisory and mentoring responsibilities add complexity to a workload that is already complex, high stakes and pressured.

Senior doctors themselves are cogs in the larger institutional organization of the hospital and beyond that of the community health system, despite having status and authority in the clinical community of the medical team on the wards. Doctors work in a professional environment where the pace, sophistication and cost of healthcare provision are constantly increasing, along with demand for healthcare from an ageing population, and a broader community increasingly falling victim to ‘lifestyle’ diseases. This leaves doctors often working under pressure to meet tight targets for hospital ‘throughput’, where patient stays are minimized in order to free up beds for new patients, and optimal patient care may be seen or felt to be under threat as a result.
(Manias et al., 2015). As professionals and as employees, these pressures may have an impact on the way senior doctors interact with their peers, subordinates and patients.

Finally, the bedside consultation is a place where different aspects of the social world collide particularly visibly. Unlike during other kinds of medical consultation, the patient is resident in the hospital and this fact brings to the fore a whole other set of issues: those of privacy, dignity, anxiety and vulnerability for the patient.

Many patients are old, may have multiple ‘co-morbidities’ (illnesses), and live alone in the community. They are often quite dependent on the support of family and community or private support services, and their hospital admission may mark or threaten to mark a point of transition away from independent living. This reality and patients’ awareness of it introduces an element of anxiety to the bedside consultation that is not relevant in quite the same way in many outpatient settings. With this anxiety periodically comes associated patient resistance to the timing and substance of proposals of hospital discharge at times that is distinctive and unique to this setting and presents a distinctive set of challenges for doctors in the care of their patients.

Although it is also similar in various ways, the bedside consultation is distinctive compared with other medical consultations. As such it is most usefully described as a distinct type of medical consultation, with unique structural features that reflect unique imperatives, constraints and purposes. These consultations occur in a setting where patients are temporarily resident, having previously been assessed as having a condition too acute in some way to be managed in the community (for the period of the hospital admission at least). The consultation’s hospital setting is also a place where medical education takes place, and one where consultations often occur in a semi-public environment. None of these conditions is characteristic of medical consultations conducted in outpatient and community settings, and they have an evident impact on interaction at the bedside.

The bedside consultation as a whole had an average duration of four minutes and 57 seconds. Changeover consultations were slightly longer (five minutes, 10 seconds)
and regular consultations slightly shorter (four minutes, 52 seconds). Despite its brevity, the bedside consultation in this study was longer than that documented in a New Zealand study (Creamer et al., 2010) where the average duration ranged from 1.50 minutes to 2.30 minutes, depending on the ward. However, the duration of UK bedside consultations had a reported average duration of 17 minutes. It is unclear what accounts for this variation however it may indicate a tangible impact of government health policy. No breakdown of internal phases of consultations in these studies is available for comparison with my data.

Several points are worth making here. The bedside consultation is surprisingly brief, particularly when given its complexity and the amount of work of different kinds accomplished during it. Particularly noteworthy is the brevity within an already short consultation, of the consultation opening. The opening itself is a complex event, when many important things are achieved which set the tone for the consultation ahead.

Overall, the fact that, at least in this data set, bedside consultations are routinely so short yet achieve so much suggests a degree of efficiency in the conduct of this work that may or may not be unusual compared with consultations in other settings (or in other hospitals). This would be an interesting topic for future investigation.

The bedside consultation is therefore not only complex, multi-faceted and distinctive in various ways compared with other kinds of medical consultation that we know about, but it is notably efficient interactionally. The fact that there seems to be a dearth of information about how work is distributed through the medical consultation in this and other clinical settings is so scarce or non-existent shows that a gap exists in the currently available research about an important kind of medical consultation which this study helps fill.

8.2 Overall structural organization

Prior research has shown that participants in medical consultations orient to an overall structural organization for the occasion that reflects the work to be done in that type of clinical context (Robinson, 2003; White, 2011; Paul, 2015). This is discussed and exemplified in Chapters 2 and 4. Consultation participants have been shown to treat
such organizational patterns as templates for the encounter (Robinson, 2003), and although progress through them may be iterative on occasion (Bryne & Long, 1976; Paul, 2015) these organizational structures remain stable and normative in their effect.

When discussing the event of the medical consultation as a whole, Robinson (2003) refers to it as an interactional ‘project (of activity)’. If we apply that analogy to the bedside consultation in the light of the findings in this study, namely that this kind of consultation has a particular structure and set of activities, it appears that the bedside consultation can legitimately be considered to be a distinctive kind of interactional project in its own right. In other words, the bedside consultation is a unique and different ‘project’ than other kinds of medical consultation.

Participants in the bedside consultation orient to a three-part structure consisting of opening, core, and closing phases. In describing the overall organization of the consultation as a three-part interaction comprising opening, core and closing, I refer back to early CA conceptions of ordinary conversation (Sacks, Schegloff & Jefferson, 1974). Although this differs from activity-based models shaping much research describing the organization and conduct of medical consultations (Heritage & Maynard, 2006), where there is no phase-based layer of description above the activities occurring within the phases, it seems appropriate for this study to include a higher level of categorization or interactional phases within which to locate activities. This simple three-part structure allows me to emphasize the link between the bedside consultation and ordinary conversation and other kinds of interaction (most of which have the same basic structure of: Opening-topics-close), while allowing its distinctiveness and internal variability to be represented.

Aspects of the conduct of the consultation help show that the participants orient to a normative organizational structure for the consultation (Robinson, 2003). This can be seen in turn-taking and turn allocation practices, and in the distribution between participants of roles for the consultation.

Evidence of participants’ orientation to the structural organization outlined above (see also Chapter 5) is twofold and can be seen in patterns of turn-taking. First, progression
through phases, activities and actions in the consultation is generally unproblematic, with little overlap and few long pauses that cannot be accounted for by a shift in mode of turn delivery (e.g. from speaking to gesture, posture change, or change in facial expression). This suggests that participants generally orient to this structural organization as normative. Second, when this normative order is disrupted, participants treat such interruptions as being incorrect or inapposite. They do this by ignoring a transgressive action by failing to produce a fitted (or any) response to it, thus thwarting the attempted change in topic or direction it represents. This happens when, for example, the patient in Extract 7, (C48) attempts to initiate discussion about when she can be discharged from hospital, too soon. In this situation, the initiator of the transgressive action (the patient in this case) marks its potentially transgressive nature with some interactional token, such as a fitted facial expression (e.g. smile).

The participant with the interactional authority to control the progress of the interaction (the doctor) can subsequently reinstate the transgressive action or activity later in the consultation, in the ‘correct’ place. This subsequent reinstatement of the previously ‘misplaced’ activity is sometimes also accompanied by some kind of expression of embodied acknowledgment, such as a smile, of the activity having been an agenda item for another participant (e.g. the patient).

Throughout the consultation participants orient to an asymmetrical interaction order whereby (as has been documented in medical interaction in other clinical settings) the doctor leading the consultation exercises a right to direct the consultation by initiating new actions and activities, thereby setting its agenda. Evidence that participants treat this asymmetry as being normative is the relative absence of attempts to subvert it by participants attempting to assume an unsanctioned level of interactional authority (e.g. by attempting to challenge the agenda). It should additionally be noted that at the bedside, where there was a medical team attending, the doctor leading the consultation is treated by other members of the medical team (as well as by patients and family members) as having the right to lead.
Pilnick et al (2005) argue that the kind of interactional asymmetry where the doctor wields the authority to set the consultation agenda and regulate its direction is functional, preferred by both doctors and patients, and is fitted to the roles that they respectively play in the consultation, and to their relationships with each other for that occasion. The evidence for this that Pilnick et al (2015) cite is the very resilience of this kind of asymmetrical interaction order despite and in the face of attempts by medical communication researchers and educators to distribute such interactional rights more equally between different categories of consultation participant over (several) recent decades. There is evidence for this same kind of persistently asymmetrical interactional order in my data as well, where doctors take the lead in agenda setting and regulation of the interaction flow, and where patients co-construct this order with little evident resistance.

The overview presented in this chapter reveals an overall structural organization for the bedside consultation that is similar in some ways to those of consultations in other settings and distinctive in others. Its purposes and structures most closely resemble those of the follow-up visit, that is itself not widely documented (White, 2011). The bedside consultation shares features with consultations of other types previously described in the literature (ten Have, 1989; Paul, 2015), such as the iterative nature of its activity sequencing, whereby some previously completed activities are returned to at later stages of the consultation. These features have been described with relation to medical consultations in other contexts generally (ten Have, 1989). Less work has been done describing the structure of follow-up consultations and it is less clear whether they also share these characteristics, but Paul (2015) documents similar activities and organization to that seen at the bedside, despite a different setting (genetic counselling) and analytic methodology (Discourse Analysis). It also shares key clinical activities such as greetings, information-collceting by the doctor (in the form of verbal and physical examination of the patient), treatment discussion, arrangement-making and, often, later re-iteration, elicitation of final concerns, thanks, and farewell sequences.

However, this overview reveals a number of unique features and structures not previously described in relation to other kinds of consultation. These include the
multi-party nature of the consultation, as well as the physical positioning of participants both of which produce participatory asymmetries that have implications for its structural organization and conduct. The bedside consultation can also be seen to contain activities not relevant (and thus not present) in other kinds of consultations. These include introductions, case presentations, specialist feedback sequences and discharge discussions, all of which reflect unique constraints and imperatives associated with this clinical setting.

These features include an iterative structure, where already completed activities are sometimes returned to at a later point in the consultation, a range of activities that often (but not always) occur during a bedside consultation, and evidence of participants orienting to a normative organizational structure and sequencing order, and the presence and involvement of an entire medical team.

Each of the broad structural phases of the bedside consultation (opening, core, closing) has its own particular internal organizational structure, made up of activities through which participants conduct the work relevant for that part of the consultation. Some of these activities are generic to interactions in general, including medical consultations, and some were more peculiar to the bedside consultation. I recap some of the findings for each of these structural phases in §8.2.1, §8.2.2 and §8.2.3 below:

8.2.1 Opening

The opening of the bedside consultation is short, occupying an average of 13 seconds, or 4% of the consultation, yet it contains a wealth of activity. Although there is a small amount of data (discussed in §2.3.6 above) showing the duration of medical consultations in hospitals, there is no information about the duration of the opening section.

The purposes of the consultation opening are broadly to reestablish the clinical relationship (White, 2011), but also to establish patient identity, and readiness to begin the consultation (Coupland et al., 1994). The fundamental tasks associated with this, apart from the administrative identity checking that is common across medical encounters in many settings, revolve around creating a connection between
participants where a sufficient degree of trust and alignment is established to allow the main business of the consultation to begin.

The bedside consultation opening contains some or all of the following activities: becoming co-present; greetings; settling in and registering; introductions; case presentations; and howareyou sequences. All face-to-face interactions involve becoming co-present, most include greetings, many include settling in and registering actions and many include howareyou sequences. However, introductions are only relevant in situations where there are people present who do not already know each other, usually in a group containing more than two people (and the larger the group, the more likely introductions are to be relevant). Medical case presentations, however, are relevant only in a particular situation or small group of situations: in a hospital (or possibly academic) setting, either in a meeting room with a team of medical staff present, or at a hospital bedside, with the patient and an attending medical team present. Similarly, offers of hospitality and complex settling in and registering activities are relevant here in ways they are not in other settings. These issues are discussed below and in Chapter 5.

This opening structure incorporates elements of outpatient consultation openings (Coupland et al., 1994; Robinson, 1998; Heritage & Robinson, 2006; Heritage & Clayman, 2010; White, 2011; Paul, 2015), and openings of ordinary conversation (Schegloff, 1968; Pillet-Shore, 2008), reflecting unique characteristics of the bedside consultation, including patient’s temporary residence in the hospital the multiparty nature of the consultation.

8.2.2 Closing

The duration of the consultation closing was an average of 19 seconds, or 6% of the entire consultation. As with the opening it is striking how quickly the often-complex work of the closing is achieved. As with the opening and the consultation as a whole, there is no available data for comparison.

Closing is an activity (as well as a consultation phase) that must be accomplished and involves often delicate negotiation, back-tracking and restarts (Schegloff & Sacks, 1973). Similarly, the closing phase of the consultation involves pre-closing and final
closing activities, many of which occur in a range of face-to-face interactions, and some which are specifically relevant to medical contexts or specifically to inpatient hospital settings. Activities in the closing of the bedside consultation that can be considered to be generic closing activities, relevant in many different kinds of interaction include: Bounding off and closing the last topic; small talk or pleasantries; making or reiterating previously agreed arrangements; goodbyes/farewells and breaking co-presence. Additional bedside closing activities also potentially relevant to consultations in other medical contexts included: summarizing the condition, eliciting (and discussing) final concerns, summarizing the condition, and eliciting final concerns. A closing activity uniquely relevant at the bedside is removing ‘bungs’ or adjusting equipment.

Doctors, patients and others orient to the necessity of a ‘proper’ closing activity to be completed before termination of the encounter can be ratified and relevantly conducted.

8.2.3 Consultation core

The duration of the consultation core is an average of four minutes, 25 seconds, or 89% of the consultation. Despite the fact that this is such a lot longer than the opening and closing, it is still remarkably short for the amount of work that occurs in it, and this is, in itself a distinctive feature of the bedside consultation.

Although openings and closings each contain elements unique to the inpatient bedside setting, and despite the setting for the openings being so markedly different to other medical encounters, it is in the consultation core that the distinctive character of the setting is most evident in the activities conducted. Information gathering includes verbal and physical examination (both specifically medical clinical activities), however two kinds of requests for feedback, called here ‘specialist feedback’ and ‘procedure feedback’ requests, are specific to the inpatient setting and reflect aspects of the hospital organizational structure not relevant in outpatient clinical settings (or ordinary social settings), namely the facts that in hospital, specialist opinions and test results may be given directly to patients before being reported to the patient’s main
doctor or physician. It also reflects the complexity of hospital routines and the fact that doctors may wish to feign ignorance of medical opinions they already know have been given or test results given, in order to test patients’ understanding of these. This latter purpose for doctors’ information requests (SFRs and PFRs) displays doctors’ sensitivity to possible effects of patients being resident for a time in the potentially confusing hospital environment and/or feeling confused because of their own medical conditions or the effects of medications on patients’ alertness. Similarly, discharge discussion is not relevant in settings where the patient (or conversational participant) has not previously been admitted as an inpatient. Discussing next steps and a future care plan could possibly be relevant in some outpatient clinical settings, but it is strongly associated with discharge in this clinical context and is consequently particularly relevant in this inpatient setting.

8.3 Unique tasks, issues and imperatives at the bedside

I have shown throughout this thesis that some activities are unique to the inpatient bedside consultation. These activities embody tasks that are distinctively relevant to this setting and mark the bedside consultation as correspondingly distinctive compared with what has been described in other better understood medical encounters. These activities are (to reiterate): settling in and registering, introductions, case presentations, SFRs, PFRs, and discharge discussion.

I have identified and described several sub-types of one of these distinctive activities for the first time: case presentations. I found that case presentations could be classified as one of the following three sub-types which I have called ‘demonstration case presentation’, ‘candidate case presentation’ and ‘peer case presentation’. It appears that these differing forms of the case presentation reflect and are designed to fulfil the communicative needs of different aspects of the educational and professional socialization work of the bedside consultation. Further research could investigate whether these sub-types occur more widely across different hospital settings, and if so, how similar their form is across a larger collection of examples.

I have also illustrated the different forms of introduction that has been described in the context of mundane interaction (Pillet-Shore, 2008) but seldom occurring or described
in these terms in medical settings. To my knowledge, this is the first time these varieties of introduction have been described in the context of the bedside consultation. This is a positive contribution to our connection and display their understanding of their relationship with each other for that interaction.

In addition, I also identified and described two distinct type of feedback elicitation activities that occurred in many of the consultations in my data, for the first time. I called these Specialist Feedback Request sequences (SFRs) and Procedure Feedback Request sequences (PFRs). These sequences appear to be multi-functional, and to have the capacity to perform a variety of distinctive tasks simultaneously. These tasks include indexing the organizational complexity of inpatient care by implicitly acknowledging the involvement of other professionals in the patient’s care, as well as establishing what expected medical opinions or tests have actually been conducted to date, as well as testing the patient’s awareness of these aspects of his/her care. Further research could investigate whether or not these sequences occur across a range of inpatient settings.

The work of the bedside consultation is embodied in the activities through which participants accomplish it, and much of this work is unique to its setting and reflects those aspects of the hospital context that are relevant to the consultation and that differentiate it from other types of medical encounter. Key activities evident in the data in this study and discussed in more detail in earlier chapters are outlined below in relation to what they accomplish and the aspect of the hospital setting they respond to. These activities help mark the bedside consultation as different from other kinds of medical consultation, and the sections below are intended to show why.

8.3.1 Managing interaction in contested space

The consultation opening, although similar in a number of respects to other types of medical consultations, contains unique activities (discussed below) that reveal unique imperatives and features of healthcare delivery in this setting. The multi-party nature of the consultation necessitates a sometimes-awkward settling in process where members of the medical team must find places in what can be a very small area around the patient’s bed during the initial moments (or seconds) of the consultation. The
multi-party aspect of the interaction is made evident in introductions, discussed below.

The space around the patient’s bed, which varies in area according to the type of ward or room the patient occupies, and is in some ways contested space, something that is evident in such settling in activities as offering hospitality. Although doctors in primary care consultations have been shown to offer patients hospitality when they (the patients) arrive in the doctor’s office (the consultation space), the space where the bedside consultation occurs is different in several consequential ways.

The bedside consultation space is not only an area that the doctor enters where the patient awaits and where the patient sometimes offers the doctor hospitality, but it is the patient’s temporary home. This creates a complex dynamic of ownership where at one level, the consultation occurs in the patient’s private territory, but at another, this ‘territory’ is actually semi-public space, ‘owned’ by the hospital, of which the doctors and other medical staff are agents, who correspondingly also have (and exercise) ‘ownership rights’. The consultation space in the bedside consultation therefore is conducted in what is (or can be) treated as contested space with both the patient and the doctor ‘claiming ownership’. ‘Claiming ownership’ can consist of the patient offering the doctor ‘hospitality’ (e.g. a seat on the bed), or conversely the doctor sitting, uninvited on the bed. The doctor can also be understood to be claiming ownership by explaining aspects of the hospital routine to the patient (e.g. “this is normal for a Friday”, C47), an action that can also be taken as an act of socialization.

Regardless of the presence or absence of ‘ownership claims’ over the consultation space, members of the medical team routinely engage in displays of respect and affiliation with the patient during the opening, such as looking at the patient, smiling, sometimes engaging in small talk with the patient but otherwise remaining quiet as they get settled in the consultation space. These actions may also be taken as displays of sensitivity to the delicate nature of the situation where a public interaction (multi-party medical consultation) occurs in a private space (the patient’s bedside) that is at the same time a public space (in a large hospital, often in a shared ward). Furthermore,
the degree of privacy is often quite limited and not only can the occupants in neighbouring beds hear conversation around the patient’s bed, but often loud conversation is clearly audible and sometimes intrusive during the consultation. A further delicate aspect of the consultation that affiliatory actions by the team may be understood to display sensitivity to is the presentational asymmetry of the consultation where doctors wear work clothes while patients wear pyjamas.

8.3.2 Managing multi-party (and multi-purpose) consultations: Introducing participants

Introductions are unusual in medical consultations and characterize multiparty encounters, such as the genetic counselling consultation (Paul, 2015). Introductions are underpinned by an assumption that parties coming together are unknown to each other and need to become acquainted so that a respectful, friendly and effective encounter can be conducted (Pillet-Shore, 2008). They play an important part in establishing (or re-establishing) connection between Introductions are a regular feature of bedside consultations, generally occurring during the consultation opening or early on in the consultation core. Their relevance reflects several features of this kind of consultation in the hospital setting that are not relevant in community settings. These features include the multi-party nature of the bedside consultation that is conducted by a medical team, and the multi-purpose nature of a consultation conducted by a multidisciplinary medical team in a teaching hospital.

Introductions also highlight the size of the hospital as a healthcare institution, where staffing numbers are necessarily high, and staff in many roles rotate weekly or daily. In the case of the medical team, its leader is rotated weekly, medical students are seconded to the team for a three-month period of clinical experience, other doctors take leave at various times, and consequently team members spend varying times ‘on the ward’. This means that introductions are particularly relevant during changeover consultations that precede the weekly change in team leadership.

A point to add here is that my analysis suggested that the interactional contrast between changeover consultations and regular consultations was not dramatic. This comparison was not a particular focus of my work and would be an interesting area for
future detailed research. Key differences that did emerge, however, include the larger
number of participants in changeover consultations, making introductions relevant in a
way they are not so relevant during regular consultations. Because of the larger
audience, and because of the nature of the changeover consultation (specifically its
purpose of transferring responsibility for patient care from one team to the next), case
presentations are generally more relevant during the changeover than during the
regular consultation.

From the patients’ perspective, their hospital stays vary in duration and their degrees
of confidence and familiarity with the hospital routine, and with the hospital staff
vary accordingly (and also with the amount of time they have spent as hospital
inpatients through their lives, especially recently). Introductions therefore constitute
an act of acknowledgment and respect displaying sensitivity to the patient’s feelings
and morale, as well as being relevant actions from a
functional administrative perspective.

The bedside consultation is also multipurpose in ways that consultations in other
settings are not. Educational functions are combined with clinical patient care work in
a busy environment that is pressured and possibly intimidating and unfamiliar to
patients.

8.3.3 Feedback requests: Organizational and clinical complexity in the hospital

Doctors’ requests for feedback from patients at the bedside about test
results and accounts of recommendations and opinions given by visiting medical
specialists who may have been to see the patient since the last ward round
visit - are distinctive information collecting activities. They are relevant at the bedside
in a way that they are not in other clinical settings, and they reflect two distinctive
features of bedside consultation. These information requests are indicative
of the organizational complexity of the hospital as a clinical environment, and of the
clinical complexity of the conditions and situation in
which many hospital inpatients find themselves.
Feedback requests by doctors to patients at the bedside are framed as requests for information. They elicit information from patients about events that have, or may have, happened since the last ward round visit, that the patients but not the doctors have been party to. However, the information these requests primarily seek is not immediately evident. The terms of the questions display an information request, and they are usually treated as such by the patients. However, these requests may also (or alternatively) probe the level of understanding the patient has about the outcome or content of a medical specialist’s visit or of the meaning or implications of test results.

There are therefore several ways feedback requests are treated by doctors in the bedside consultation. The first two are aimed at information collection, and the questions that convey the information request are framed identically, but doctors use them to elicit different kinds of information. First, doctors treat feedback requests to elicit actual facts (such as whether or not a specialist has visited the patient since the last ward round visit and if so, what they told the patient). Alternatively doctors already have the information about the specialist’s visit and its outcome on file and seek to assess how well the patient understands what (according to file notes) has happened.

Three other possible purposes feedback requests may fulfil are, first, acting as a form of ‘safety netting’ to check that the patient has been visited as expected by a particular other doctor or has actually been given a scheduled test. Alternatively, or in addition, such requests may be a means for the doctor to display his or her awareness of the contributions of other colleagues the patient’s care. Finally, these requests may fulfil a socializing role for the patient, whereby the involvement of multiple practitioners in providing clinical care is made explicit.

As mentioned above, this type of information-collecting activity is quite common during the bedside consultation and it projects and is symptomatic of the complexity of this clinical setting. Its ambivalent purpose reflects a number of aspects of the inpatient setting that are distinctive and unique: the level of illness or incapacity experienced by some hospital inpatients; the complexity of some patients’ medical problems or ‘co-morbidities’; the organizational complexity and busyness of the
setting; and the periodic lack of direct communication between medical practitioners about patients they ‘share’.

8.3.4 Case presentations: Clinical teaching and learning, and professional socialization

The case presentation is another activity uniquely characteristic of the bedside consultation that emerges in the structurally focused analysis of this study. The case presentation embodies an important and distinctive aspect of the work of inpatient care at the bedside, namely the demonstration of clinical skills by senior clinicians and of their mastery by junior doctors. The case presentation exemplifies teaching and learning at the bedside and activities can be organized to allocate a range of roles to doctors, patients and junior doctors or students, with varying levels of active involvement (Monrouxe, Rees & Bradley, 2009). The patient experiences a level of attention that may not feel comfortable, as well as providing access to information about their health in professional terms. Patients sometimes display embarrassment during the case presentation, but doctors often display corresponding sensitivity to the patient’s discomfort, by providing reassurance in the form of gaze and smiles.

The educational and socializing aspect of the inpatient consultation is linked to its hospital context and the opportunity this setting offers junior doctors and medical students to gain supervised experience of inpatient medical care and to watch it being practiced by experienced clinicians. The fact that the organization of the activity of the case presentation reveals different aspects of the educational and socializing dimension of the consultation validates the structural analytic approach to this data as a means to gain understanding of different dimensions of this work and how it is done.

Case presentations are structured in such a way as to show that participants assume different interactional roles complete with varying associated rights and responsibilities, depending on whether the presentation is being given by a junior or a senior doctor. The identity of the case presenter signifies the type and purpose of the case presentation, and this is encoded in the distribution of interactional rights between participants. Senior doctors deliver demonstration presentations that have to be silently observed and not interrupted by juniors, while juniors can be interrupted by
senior clinicians or have suggestions or comments made, or questions asked at various points during the consultation.

### 8.3.5 Discharge discussions: Issues involved in leaving hospital

Discharge discussion is a potential flashpoint in the consultation, where multiple competing interests and agendas can play out in the interaction. Doctors often manage competing pressures concerning discharge. There may be pressure from the hospital to free up beds to optimize patient occupancy (and thereby maximize government funding received), with an associated push to discharge patients as soon as possible. On the other hand, allied health workers such as social workers advocate for patients and may push for them to remain longer. Doctors themselves may prefer to minimize the paperwork associated with movement of patients in and out, so may be happy for them to stay longer, and on top of that, is the clinical decision making that may perhaps be assumed to be the only consideration for the doctor.

Discharge discussions are uniquely relevant in an inpatient setting, not only highlight the distinctive residential character of the consultation but also reveal larger tensions concerning patients’ hospital admissions that come to light during the consultation. The way these tensions are dealt with in the discussion highlight the asymmetrical distribution of interactional authority between the participants, which both (all) orient to in that communication.

For example, some patients (usually younger participants) display a keenness to leave hospital (as discussed in Chapter 4), an enthusiasm that the doctor often acknowledges, whereas other (often older) patients, display the opposite preference, namely a reluctance to accept the proposed discharge timetable on the basis that it involves the patient being discharged sooner than they would like (discussed in Chapter 6). Doctors often acknowledge these expressed preferences to stay or leave hospital, but frequently do not accommodate them, particularly requests to stay longer.

Discharge discussions sometimes function as informings rather than as discussions, because despite patient resistance, the original discharge proposal presented by the
doctor invariably ultimately prevails (discussed in Chapter 6). The fact that these ‘discussions’ work in this way shows that both doctors and patients orient to the doctors’ ultimate professionally and socially warranted authority to decide about the timing and nature of patients’ discharge from hospital.

On other occasions, doctors trigger a discussion about discharge by asking patients if they want or are ready to go home, or alternatively if they want to spend time in respite care before returning home (discussed in Chapter 6). Occasionally the patient initiates discussion about discharge by requesting it him- or herself.

In discharge discussions, elements of a wider social context are evident (part of Mischler (1984)’s ‘life world’), and unlike during clinic-based outpatient consultations, this is the only point where the ‘life world’ emerges at the bedside. The way doctors’ responses to patients’ positions regarding discharge reveal not only the limits of the patients’ agency or capacity to negotiate different ‘terms’ of their care, but it also displays the extent and limits of the doctors’ agency in the consultation. Doctors’ repeated refusal to accommodate patients’ wishes (especially wishes to stay in hospital longer), and alter apparently pre-arranged discharge plans, suggest that the doctors themselves may be constrained by larger institutional pressures such as hospital requirements for minimizing the duration of inpatient stays. Doctors rarely explicitly explain the reasoning behind the proposed timing of discharge, although they sometimes justify its nature in general terms. This may also indicate reluctance on the doctors’ parts to discuss the role resourcing issues such as pressure for hospital beds may play in decision making about duration of hospital stays for individual patients, and the associated timing of discharge.

Patterns of patient response to discharge proposals presented by doctors varies in a similar way that patient responses to medical recommendation has been shown to do (Stivers, Heritage, Barnes, McCabe, Thompson & Torien, 2018). Sometimes patients delay their responses to doctors’ discharge proposals displaying resistance to the proposals by withholding acceptance of them (§6.3.5, Extract 44) or else displaying active resistance (C5). When this happens, the patients’ responses impose pressure on doctors to justify their proposals and present more evidence to show that their
suggested plan is sufficient to ensure patients’ future care and safety, reassure patients and address their concerns or reservations. In this way, the negotiation that sometimes occurs during discharge discussion, when patients resist doctors’ proposals of discharge plans and force doctors to justify their proposals in order to secure patient acceptance of the plans is similar to the process of negotiation described by Stivers (2006) in relation to treatment plan proposals in community clinic consultations where patients are normatively required to align with the treatment recommendation before the consultation can progress to a next stage. Further investigation of parallels between the process of negotiating discharge plans and treatment plans would be a valuable and interesting topic for future research.

When patients express concerns, these are sometimes overtly expressed (e.g. \textit{P:} “I’m not ready to go home” (C7)) and sometimes expressed in more veiled terms, with the precise nature of the reservations more hinted at than clearly articulated (e.g. to be confident in their safety and health at home/back in the community as in \textit{P:} “I live alone … and uh(0.2)I really need assistance” (C34)).

Discussion about discharge arrangements occurs once the patient’s condition has stabilized and it involves discussion and negotiation with the patient. This activity is usually treated as a final or the final item of business, but it sometimes occurs earlier and is revisited during the closing.

Discharge planning is relevant in an inpatient setting where patients are temporarily resident in the hospital and had to leave – be discharged - at some time. Patients are discharged from hospital when their condition has stabilized sufficiently, according to the clinical judgment of the clinicians responsible for their treatment and care, for them to be able to continue their recovery in another clinical environment, or alternatively, when they have fully recovered and need no more intensive medical or allied care. At the point of discharge from hospital, doctors either refer patients to a rehabilitation facility where less medically intensive therapy is available, or ‘clear’ them to go home.

Patient discharge is the goal towards which diagnosis and treatment are directed. Discharge is also the goal for many (but not all) patients in relation to their hospital admission and stay. Medical care is directed at identifying then treating the patient’s
clinical symptoms and condition. Its focus is therefore to discover the nature and cause of the patient’s medical problem and finding a way of effectively treating it to the point where is either eliminated entirely and cured or contained to the point where the patient can continue living independently to the maximum possible extent, in the community.

8.3.6 Interactional asymmetry: Managing agency and authority in the consultation

Doctors overwhelmingly exercise control over the trajectory and direction of the interaction throughout the consultation, routinely initiating new activities or reinstating previously conducted activities (as discussed in Chapter 4 in relation to C48). Not only do they exercise this interactional control, but doctors on occasion (usually indirectly) sanction challenges to their normative dominance by patients or others. Significantly, patients generally accept this medical control and (deontic and epistemic) authority and seldom resist it, a pattern indicating orientation by (all) participants to this kind of interactional asymmetry.

Beyond the issue of interactional control and authority, participants in the bedside consultation orient to the distinctive overall structural organization explored in this thesis, which although distinctive in its character and activities, is recognizably that of a type of medical consultation. This includes orientation by participants to a normative order of activities, albeit via an iterative process, as well as orientation to the particular distribution of interactional roles for the consultation.

Part of what participants in this study clearly orient to and which the literature has also shown to characterize medical consultations in a range of different settings (Roberts, 2000; ten Have, 1991) is asymmetry between doctor and patient in terms of interactional authority. Pilnick and Dingwall (2011) argue that, rather than being problematic as much medical communication literature suggests, this kind of asymmetry is functional and is an intrinsic part of the normative roles of doctor and patient.

The idea that interactional asymmetry in the medical consultation – where the doctor has a more active role in directing the interaction than the patient - is undesirable and
results in a sub-optimal experience for the patient is frequently expressed in medical communication literature. Reduction of this asymmetry has been recommended as an important goal of ‘patient-centred medicine’ and is driven by the assumption that it is better for patients to take a more active (speaking) role in discussion and decision making during the consultation.

Means are sought to encourage more active patient engagement in discussion and decision making during the consultation, and efforts to encourage and promote such patient-centred medical practice have extended to medical training programs that aim to promote strategies designed to encourage more patient involvement in the consultation by various means including through better clinician ‘communication skills’ and intra-professional pre-service reflection (Kent, Hayes, Glass & Rees, 2017).

There are problems with this set of assumptions about asymmetry and patient involvement in the consultation. First, the idea that patient (or doctor) engagement is limited to speech ignores abundant evidence of the range of means other than speech by which participants (including patients) can be involved in interaction. For example, gaze is an important mode of engagement (although it is silent) (Rossano, 2012), for example during story-telling when the normal rules of speaker change are suspended (Jefferson, 1978) audience members are silent but remain actively involved as they watch and listen to the narrative. In this situation gaze and often head-nodding (Stivers, 2008) is normative as a relevant form of recipiency.

Second, patient involvement and epistemic or deontic (medical) asymmetry can coexist, so that asymmetry in speech can coexist with patient engagement by other, embodied means. Indeed, an embodied display of recipiency, such a head nod (Stivers, 2008) may be accountable, as Zama and Robinson (2016) show in relation to student advisors and students.

Pilnick and Dingwall (2011) invoke Parsons (1951)’s proposal that social order is maintained by locating citizens within a set of norms, to support their argument that an asymmetric relationship between doctor and patient is functional, not
problematic. Citizens outside agreed social norms are considered to be there either voluntarily ('motivated') or involuntarily ('unmotivated'). Social structures incorporate gatekeeping roles and procedures for assessing citizens who deviate from the norms, for assessing their deviation as being motivated or unmotivated, and (conditional) routes back to ‘normal’ status.

The role of doctor is one such gatekeeping position in Parsons’ model, with the patient playing the would-be ‘sick role’. The doctor’s gatekeeping responsibilities involve assessing the patient’s claim to sickness, and thereby to standing as involuntarily outside the norm and (temporarily) exempt from the social expectations carried by ‘normal’ people. If the doctor judges the patient to be genuinely sick (an ‘unmotivated deviant’) s/he is responsible for devising a plan by which the patient can return to ‘normal’ life. A diagnosis confers the ‘sick role’ to the patient, and the treatment plan articulates the doctor’s proposed route for the patient to take to return to normal health.

If the doctor decides that the patient has no genuine claim to status as ‘sick’, then exemption from normal duties and demands that come with the ‘sick role’ is denied, and the patient is obliged to either return to ‘normal’ life without support or accept sanction as a malingerer. Within this conceptualization of the doctor patient relationship, the patient is cast as supplicant to the doctor and in need of the doctor’s support and acknowledgment. The doctor wields considerable socially sanctioned authority and power over the patient and his/her ‘healing’ role is cast in a socially ‘functional’ light, rooted in a “much larger discussion of deviance and social order and of the functional problems that all social groups face in reconciling order and diversity so as to sustain membership and innovation” (Pilnick & Dingwall, 2011:1380). Pilnick and Dingwall argue that this larger social context explains the persistence of doctors’ interactional dominance in medical consultations even in the face of efforts over 40 years to facilitate a greater degree of interactional symmetry between patients and doctors in consultations through improved ‘communication skills’ by doctors and provision of more opportunities for involvement and more welcoming interactional environments for patients.
Another way that doctors appear to orient indirectly to the asymmetry that characterizes their relationships with patients at the bedside is how they display awareness of the patients’ potential vulnerability in various ways. These include informing patients about hospital routines (discussed in Chapter 5) – thus displaying an expectation that (particular) patients may be unaware of these routines and as a result may experience a sense of confusion. Doctors also display sensitivity to patients’ possible confusion about information they (patients) have been given by making inquiries about specialists’ opinions (SFRs) and test results (PFRs) which are both framed as genuine requests for information, that is face-saving for patients who happen to have been given the information previously and have forgotten or not understood them. The fact that SFRs and PFRs are information collecting activities that may also be a means of testing patients’ understanding (as discussed in Chapter 6) does not mean that they do not simultaneously act to display awareness of and provide possible support in the face of patient vulnerability and confusion.

It should be emphasised, however, that an asymmetry in balances of agency, participation and involvement do not necessarily display the effective exclusion of patients from active engagement in the consultation. They may simply be features of a situation where patients engage in forms of participation that are different from those in other social or clinical settings. There was evidence of this in my data. These may be distinctive to this data set or this setting, or they may not be, but may be less well understood than some other forms of involvement.

8.4 Establishing connection, and managing asymmetry and anxiety

Laughter, teasing and joking feature in medical discourse as a means of managing delicate moments and sensitive issues that emerge in the consultation (Beach & Prickett, 2017; Haakana, 2001; 2010; Jefferson, 1984; and others), and also as a means by which participants (chiefly patients) exercise agency by pushing back at asymmetries of authority (Rees & Monrouxe, 2010). In general conversation, laughter, joking and teasing have been shown to be capable of being affiliative and/or disaffiliative (Drew, 1987; Glenn, 2003; Glenn & Holt (eds.), 2013; Clift, 2016a; Holt, 2010, 2016. Laughter, joking, teasing and smiling are a recurrent feature of interaction at the bedside during ward round visits in this
study. However, their manifestation at the bedside, despite having similarities with that reported in other clinical contexts, is distinctive, and it highlights unique features of clinical care at this setting.

Laughter, teasing and joking at the bedside are important strategies for establishing connection and affiliation between participants, ‘making light’ of anxiety (by drawing attention to anxiety in such a way as to display ‘troubles resistance’) and for exercising agency from a position of relative disempowerment (such as by patients making fun of doctors’ professional status, see Extracts 12, 13, p. 179) Patients usually initiate jokes (although not always, see: D: ‘You’re famous’, P: ‘No you are,’ C45, §5.3.3.1), and doctors often either ignore the jokes or produce only a minimal response, a pattern documented in the literature concerning joking in medical discourse (Haakana, 2001; 2010; Holt etc.). Occasionally doctors produce second or counter jokes, which usually are ‘bonding’ in character (see Chapter 5).

The roles played by joking are important as ‘backstage’ ways of introducing potentially sensitive or diplomatically dispreferred issues or positions. Humour – whether it was in the form of a joke or as laughter – can be used to project distance between the joker and the substance of the joke, while at the same time claiming affiliation with the idea it conveyed (tongue-in-cheek) by the mere fact of having made the comment.

Laughter, joking and teasing are most evident during the consultation opening and closing phases, when participants work to achieve interactional engagement and affiliation and disengagement respectively. Laughter has been described as having the capacity to be “bonding or biting” (Boxer & Conde-Cortes, 1997), and at the bedside in this data, it is used in both ways but is predominantly deployed as a bonding or affiliatory strategy. As is discussed in Chapters 5 and 7, participants – usually patients – often initiate teasing comments and invitations to laugh to position themselves in relation to the medical staff or to identify common ground they share with the doctors by referring jokingly to common experience, especially that of being filmed. Occasionally laughter or invitations to laugh are used to ‘bite’, usually by patients, and (for example) teasing is used to use a construction of common
ground shared by doctor and patient as a basis for an unflattering interpretation of
doctors’ actions, attitudes or motivations. Occasionally doctors make
a disaffiliative ‘biting’ joke, on one occasion backstage, between themselves, at the
patient’s expense, possibly not intended to be overheard, but audible, other times
incorporated into the conversation but treated by patients as ambivalent or weakly
affiliative. Such disaffiliative use of and response to laughter by doctors is rare,
however, serving to highlight their predominant sensitivity to the vulnerability or wish
to forge connection that they treat as driving patient laughing and jokes.

8.5 Limitations

This research presents a structural overview of the bedside consultation, including
accounts of what and how different activities are organized and conducted, which
allowed me to focus on how participants displayed their understandings to each other
in the timing and construction of their interactional turns and contributions. This
overview is therefore basically observational and does not show a clear meta-
commentary of the consultation, however, that inclusion of interview data would allow
for. While I did collect such data, with the original intention of providing a more
multi-dimensional account of the consultation, this turned out to be beyond the scope
of the structural focus of the final thesis but can be the focus of future research.

This possible limitation notwithstanding however, it could also be argued that the data-
focused empirical observations of CA may have greater strength and authority than
‘second hand’ reported impressions.

This is not necessarily problematic, however, because there is value in relying on what
can be observed empirically in data, and ‘pure’ CA forbids the inclusion of any other
kind of analysis. Instead, it can be seen that the availability and inclusion of different
kinds of data makes different analytic approaches and methodologies possible and
relevant. Had the interview data been included in this study, a different (e.g.
interactional sociolinguistic) approach and study design would have been followed,
with hopefully interesting results. However, the study approach design as it stands had
the advantage of allowing me to focus in more detail on an interesting and important
aspect of the bedside consultation (its structure at different levels and some of its
distinctive interactional features and challenges) than would otherwise have been possible.

The fact that the data on which these results are based was a small convenience sample collected at a single hospital over a limited period (approximately one year) is acknowledged. This aspect of the research has clear implications for the generalisability of results and the ability to make claims about what my findings mean for our understanding of the bedside consultation as a broader phenomenon. However, this limitation does not invalidate my findings or render them worthless. It merely limits what I am able to claim about the place of my findings in the broader sum of our knowledge about medical consultations in general and bedside consultations in particular.

I position this research as a kind of extended case study: a ‘snapshot portrait’ of a kind of consultation taking place in a particular setting over a particular period in time. I argue that this study offers insights into different aspects of the way the bedside consultation can be and is done in certain circumstances. This includes new information, and as such, is a small but worthwhile contribution to our understanding about how this kind of inpatient care is ‘done’ and delivered.

Similarly, the fact that I chose to produce a general structural overview of the bedside consultation using the interactional video data, means that it was beyond the scope of the study to focus in detail on facets of the interactional data less directly related to the organizational structure of the consultation. Such elements include modes of embodied action such as gesture and gaze.

For example (to name just a few of the research possibilities that were impossible to pursue), limited space made it impossible to relevantly incorporate analysis of the interview data, which will be published separately, to explore participants’ reported experience of the consultation, and/or to superimpose this information onto the observational data derived from the videotaped consultations. Each of the activities identified in the consultation data could also have been investigated in more detail and
from different angles, and alternatively (or in addition), the data could have been analyzed through a language socialization lens.

Against these limitations, there were also strengths in this study. I believe that the strongly data-based empirical investigation provided a vivid picture of different aspects of the bedside consultations in my data. My aim of generating a ‘broad brush’ portrait of the consultation was to create the kind of overview that is may provide a general impression of the bedside consultations I investigated and highlight some of their interesting features. This may in turn open up new ideas for future investigations.

8.6 Future directions

A number of issues could be interestingly investigated in future research into the bedside consultation. Some of these were mentioned in the section above. More detailed study could be conducted into the unique activities of the bedside consultation, such as discharge discussion, case presentations, introductions, and information gathering through requests for information from patients about specialist feedback and test results. The way participants use question sequences to accomplish different interactional goals could be investigated. This could include looking at where different kinds of question designs occur, what they do (in terms of the actions they accomplish) and who initiates them.

The perspectives of participants regarding aspects of their understandings or views about the consultation could be investigated. This could be done using interview data such as that collected but not included in this study. Such investigation of participants’ perspectives would be interesting in its own right and also if linked up with the interaction to which it referred. Similarly, more detailed accounts than has been possible here, of how embodied resources are deployed in different ways during the consultation could be explored. For example, research could focus on how gesture and gaze contribute to the accomplishment of tasks in the consultation and also how participants use them to express emotional states such as anxiety or pain or accomplish different specific interactional objectives could be the focus of future research.
I note that the consent forms for this study (Appendix 3) were designed in such a way as to enable me to use my data, including interview data which limitations in scope prevented me from including in this thesis, (as mentioned in Chapter 3) in just this way. This was a precaution intended to preserve data that could not be used in the first instance to remain available for future research.

The bedside consultation could also be investigated in combination with detailed accounts of the corridor encounters between the medical team before and after the bedside consultation. In this way, the individual ward round visit could be better understood as an interactional event. The bedside consultation that is at the same time a (n entire) ward round visit, namely one conducted by a single doctor could be investigated in terms of its overall organizational structure, conduct and activities, so that the impact of the number of doctors present on the form and conduct of the bedside consultation can be better understood.

Participants’ reported understanding and perceptions of activities and actions conducted during the consultation could be investigated to provide triangulation for observational accounts of the bedside consultation such as this study provides. Alternatively, the bedside consultation could be investigated through a language socialization lens, as an episode of socialization both for junior doctors and medical staff, and also for patients.

Socialization is an interesting theoretical perspective from which to consider the case presentation and more broadly, the bedside consultation. It is relevant not only to junior doctors and medical students at the bedside but also to patients, who are socialized into the routines and practices of the hospital.

The provision of professional socialization to junior doctors and medical students is a given in the context of a training environment, at either or both explicit and implicit levels. However, patients may not have previous experience of being hospitalized, or of being an inpatient at this particular hospital. In either of these situations, patients may be unfamiliar with the hospital routines and also possibly, of the experience of being an inpatient in general. As seen in this study, doctors sometimes orient to
patients’ possible lack of inpatient experience by referring to aspects of the hospital routine (§5.3.3.1). It was beyond the scope of this study to investigate the issue of socialization for different participants at the bedside. These issues could, however, be pursued in future research. Included in further investigation of socialization, the socialization of doctors in this setting could also be and interesting focus.

Activities that characterize the bedside consultation, but which have not been widely discussed in relation to other clinical settings, such as the activity of registering during the consultation opening, could be investigated in other hospital and community medical clinical settings, in order to establish whether or not it is unique to the bedside and if not, how it manifests and exactly how it works in other situations.

In addition, the bedside consultation could be investigated in another cultural setting, or at another type of Australian hospital, such as at a non-teaching hospital or at a specialist hospital (such as a rehabilitation hospital, a psychiatric hospital, a children’s hospital or a maternity hospital) so that more could be learnt about how issues specific to particular other inpatient clinical settings emerge and are managed by participants.

8.7 Conclusions

This study contributes to our understanding of a relatively understudied type of medical consultation. Not only is the bedside consultation conducted in a tertiary (hospital) setting, unlike consultations that occur in a community setting, which form the basis of much previous interactional medical communication research, but it is, broadly speaking, a follow-up consultation, which is another type of relatively less well documented type of consultation (compared with the initial consultation in a primary healthcare setting).

From a methodological perspective, the use of video data as the basis for analysis is increasingly common and provides access to a similar range of information as is available to participants themselves and as such is rapidly becoming if not a default then a very widely used data source in medical communication research. This means that this study sits comfortably within the very substantial and growing body of medical communication research focused on different aspects of interaction. The
researcher is a professional ‘outsider’ in the medical clinical context, ensuring that the data is uncomplicated by the confusion among participants about her role in the consultation reported in some other research, where participants refer to the professional knowhow and experience of professional ‘insiders’ who are, for example, also medical doctors (Urquhart et al., 2018; Burns, Fenwick, Schmied & Sheehan, 2012; Dwyer & Buckle, 2009).

It must also be acknowledged that despite the advantages of the researcher’s ‘outsider’ status during the consultation, the fact remains that an outsider was present during consultations and was observing and filming them, and participants knew this. At times this participant awareness was evident in the data (§5.3.3.1, Extract 21 (C20)). However, in contemporary communication research of this kind, this issue is unavoidable and overall it does not appear to have contaminated the data too greatly in this case.

This study offers a structurally based overview of the consultation, through which it provides snapshots of participant orientations, roles, priorities and concerns and how they work together to achieve their objectives in a complex, high-pressure medical environment involving potentially particularly vulnerable patients.

A CA-type methodological approach to analyzing the study data provides the means to identify ways these features of the bedside consultation are evident in the organization and conduct or the interaction between participants. Because of the vast existing literature of CA studies focused on medical interaction and of the structure and organization of medical consultations in particular, this approach makes it possible not only to describe what goes on during the bedside consultation but how it compares with what happens during other kinds of medical consultation.

A number of important features of the bedside consultation were identified and described in this thesis that have not been described as occurring in other clinical settings. I suggest that this means that the bedside consultation that occurs as part of the daily ward round can be considered sufficiently different from other consultations to be classified as a distinctive type of medical consultation in its own right. It is an event where unique considerations shape the work and organization of the
This study has shown that the bedside consultation that occurs as part of the daily ward round visit has an overall structural organization, internal organization, and activities to which participants orient that is somewhat similar to other kinds of medical consultation, but distinctive in various important ways. The consultation structure is shaped by the work it facilitates, and its distinctive structural features (such as unique activities) reflect distinctive tasks done and sensitivities and issues managed.

This study provides an overview of distinctive activities occurring during the bedside consultation, and also of interactional issues relevant to consider in assessing or reviewing the bedside consultation and aspects of healthcare provision in that setting. Evidence from the study suggests that there are unique sensitivities arising in this context for the patient regarding privacy and dignity, also anxiety, disempowerment, and vulnerability. However, evidence in this study shows that in the main, doctors are mindful of these sensitivities and act to display awareness and responsiveness to them.

The involvement of a medical team in the consultation, and the fact that it takes place in a teaching hospital are shown in this study to be two of the factors that may (among other things) set it apart as a consultation type with complexities greater than those of medical consultations in other settings. Bedside consultations such as those in this study can be seen to be events where there are interlocking and sometimes competing agendas at play. For example, leading doctors must supervise junior doctors and medical students while simultaneously conducting the consultation and managing issues surrounding the medical care of the patient as well as responding to related anxieties or uncertainties the patient may express explicitly or indirectly. Doctors must also make decisions about patient care balancing potentially competing demands of clinical imperatives or ideals with institutional constraints including budgetary limitations potentially involving pressure to optimize the availability of hospital beds and hasten patient discharge (Brown & Sorrell, 2009).

On the other hand, there are many features in addition to the setting of these consultations in a teaching hospital that set it apart from medical consultations. It is
likely that a study of bedside consultations attended by only a single doctor would share a number of the unique seeming characteristics evident in this data. These include, for example, but are not limited to the fact that the patient is temporarily resident in the hospital, with the many associated complexities that were evident in this study.

Patients must potentially manage discomfort and anxiety related to their condition, which is severe enough to warrant hospitalization, as well as anxiety relating to how they will manage after discharge from hospital, in addition to feelings of disempowerment, embarrassment and confusion relating to the physical and organizational conditions of the consultation.

Medical students and junior doctors must remain attentive and engaged despite often playing no active role in the consultation, which is one of a number of consultations in the round. At the same time, they must be ready to help when requested, potentially respond to questioning from the supervising doctors and also display their mastery of clinical skills by leading consultations themselves while being observed by the rest of the team, the supervising doctor, the patient and any additional medical staff or patient supporters (such as family members). Any or all of these demands may create anxiety as well as interest, excitement and enthusiasm for these beginning and aspiring medical professionals, which they must learn to contain and manage as they project the necessary professional balance between engagement and detachment in interactions with patients and their peers.

The study has contributed insight into the mechanics of explicit and passive clinical teaching and supervision of junior doctors and medical students ‘on the wards.’ The process of formal clinical teaching and socialization is partially revealed in the different formats of case presentations (discussed in more detail in Chapter 5) where different stages of demonstrating, teaching or scaffolding and practising target skills can be seen. Meanwhile informal demonstration and teaching is evident throughout the consultation when junior doctors conduct entire consultations under the guidance of senior doctors and are included by way of questioning at points during consultations led by a senior doctor. Through these
perspectives, a sense of the range of experiences and opportunities for varying levels and types of active involvement available to junior doctors depending on their degree of experience is evident.

Communicative asymmetry between doctor and patient with regard to interactional (as well as presentational (Jenkins, 2014) authority is evident at the bedside. However, members of the medical team display sensitivity to the patient’s relative disadvantage in the encounter in terms of dignity of personal presentation and exposure (lack of privacy), as well as the more obvious asymmetry related to level of health. In addition, patients generally acquiesce to this asymmetry in what can be seen as support of the notion of its functionality “in the local order … embedded within a wider functionality of the institution of medicine in society” (Pilnick & Dingwall, 2011:1381).

People enter hospital as patients, for a range of reasons, some relatively minor and some potentially life-threatening, but in every case, something needs to be attended to which cannot be adequately dealt with outside the hospital environment. In assuming the role of hospital inpatient, a person must submit to the demands, protocols and comfort of the institutional routines of the hospital. Meals are provided, housework attended to, round-the-clock expert professional medical care is available and the medical issues responsible for hospital admission are tackled. There may be comfort and relief for patients associated with hospital admission or dread and confusion. There may be a sense of security in getting care, help or intervention that is desired, or ambivalence at what may seem like unnecessary or unwanted confinement imposed by well-meaning doctors and family. There may be eagerness to make a quick return to active healthy life after a relatively minor procedure or a sense of impending doom and fear about whether death or increasing frailty will make discharge possible, or if discharge does occur, how life at home or in some other kind of institution will be manageable.

In addition to these emotional and therapeutic issues is the loss of privacy experienced by many hospital inpatients in shared wards, and during consultations where a team of people is present. For all these reasons, hospital admission for whatever reason
disempowers patients to a degree as they become integrated into hospital processes and routines. This makes them vulnerable in ways that patients seeking medical care in community or outpatient contexts, however ill they may be, are not.

At the same time, doctors in this setting wield unique interactional power in their roles as ‘healers’, carers, diagnosticians, institutional gatekeepers and representatives as well as guides and teachers of a new generation of doctors and aspiring medical practitioners. This is so despite the pressures imposed on them by the combination of institutional routine and administrative imperatives, complex web of professional responsibilities, and associated emotional demands.

Hospital inpatients are vulnerable, time is short, limited resources may generate a sense of urgency in the way things are done, and for these reasons it is important to understand more about how their care is delivered in the bedside consultation which is at the heart of possibly the most frequent medical visit in the health system, the daily ward round. How is the bedside consultation is organized and conducted in ways that address the issues, imperatives and tasks discussed in this chapter and throughout this thesis? How do patients and doctors cooperate to do their work at the bedside? How do patients articulate their concerns, how are these received by their doctors and how is clinical training incorporated into the consultation?

This thesis contributes to our understanding of how multiple medical, clinical, emotional and institutional agendas interlock and are co-constructed by doctors, patients, members of attending medical teams and family members at the bedside, day after day, in a type of consultation that has until recently been overlooked in the medical communication literature. The bedside consultation turns out to have a structural organization both at the level of complete episode of interaction and within subsidiary phases. which while recognizably ‘a medical consultation’, has a distinctiveness that reflects its unique range of participants, agendas, tasks, imperatives and dilemmas.

The uniqueness of the bedside consultation is revealed this interactional ‘snapshot’ or ‘portrait’. In focusing on how the bedside consultation is constructed and conducted as
an interactional event, this study shows the way participants do their work. It shows how participants listen and respond to each other, invite or discourage participation, manage delicate moments, manage competing agendas, display anxiety, confusion, disempowerment or embarrassment or a wish to leave or stay longer, demonstrate desired professional or clinical skills and display the level to which these have been mastered are all illuminated.

To participate in the bedside consultation during a daily ward round is to be involved in a crucial episode of medical care that may at times seem invisible because of its frequency but in some ways lies at the heart of our healthcare system. It involves caring for acutely ill or incapacitated people, training and socializing the next generation of doctors, giving voice to the vulnerable, dignity to the disempowered, and reassurance to the fearful. It involves facing sickness, loss, confusion, anxiety and pain, finding a voice or submitting to the care and direction of others. It involves witnessing the suffering of those dear to you, their medical treatment, and advocating for them. This quietly commonplace event is vitally important and uniquely complex and needs to be better understood so that the needs of all involved can be met.

Although much is now known about aspects of how the bedside consultation is conducted, more still remains to be learned, so that patients receive the care they need and have their voices heard and experience of all involved can be optimized.
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Appendices

Appendix 1  Ward round categories

Appendix 2  RACP Professional Communication Skills for Doctors

Appendix 3  Ethics Consent, Information and Permission forms

Appendix 4  Ward layouts

Appendix 5  Transcription Conventions

Appendix 6  Sample consultation transcription

Appendix 7  Examples of CA concepts and other interactional features
Appendix 1  Ward round categories

A recent summary of different kinds of ward round was produced by Walton, Hogden, Johnson & Greenfield (2016). It was an attempt to articulate the range of types of ward round carried out in Australian hospitals, in the face of a dearth of such information. They use one of the following characteristics to name a (ward) round category or type: its location, timing, participants or purpose, as determined by “identifying keywords in the description of why the ward round was carried out” (Walton et al (2016:367)). The eight types of (ward) round they name are: ward, multidisciplinary, consultant, teaching/education, post-take, traditional, working, and review rounds. Although Walton et al (2016) do not discuss the frequency of each of these types of round, other categories of (ward) round7 are described elsewhere in the literature as varying from daily (or more) to weekly (Ahmed et al., 2009), and their characteristics are outlined in more detail below.

1.1 The ‘Ward round’
The ‘Ward round’ is the most frequently described type of round identified by Walton et al (45%, n=21), and it is presented as a category the characteristics of which frequently overlap with those of other round types. The Ward round occurs daily, each morning, when a team of doctors, led by the supervising doctor who conducted the initial assessment round described above, accompanied by junior medical staff and students, and possibly also allied staff such as nurses, physiotherapists, pharmacists and/or dieticians. Its overall objective is to assess the patient’s situation: his or her condition, the treatment plan, prospects and plans for discharge from hospital, and the identification of any new issues that have arisen since the last round, or since admission if that occurred after the previous day’s ward round (Kirthi et al., 2012).

1.2 The ‘Multidisciplinary round’
The ‘Multidisciplinary round’ is widely promoted as a useful type of ward round because it brings together a range of clinicians involved in patient care, all of whom have different and useful information and perspectives to contribute to the event.

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7 Post take ward round, daily ward round, foundation doctor ward round, consultant ward round in Ahmed, Rutter & Neequaye, 2009. Kirthi et al (2012) describe the following types of ward rounds: senior review (similar to ‘post take’); post-take review; daily scheduled clinical review; pre-discharge review.
Walton et al list four categories of attendees: medical officers (senior and junior doctors), nurses, allied health workers and patients. Medical officers are responsible for the following tasks: “…leadership; documentation; patient care combined with leadership; and patient care combined with education…” (Walton et al., 2016:372). The distribution of these roles between the doctors was not fixed, with doctors of different levels of seniority taking different roles. There is however a designated leader, who coordinates communication between all present. This kind of round comprised just over a fifth of Walton et al.’s sample (21%, n=10/47), and was the second most frequent category. Its purposes include assessment of patient condition and review of care plan, medication management, discharge planning and discussion of patient concerns.

1.3 The ‘Consultant round’
The purposes of the ‘Consultant round’ are to provide patient care (Strickrath et al., 2013), to review and plan teaching, and to simultaneously provide teaching and learning opportunities for junior doctors (Castiglioni et al., 2008). This is the third most frequently occurring round in Walton et al.’s data set, with an occurrence of 11% (n=5/47). The consultant round occurs approximately weekly and is led by a specialist consultant and his or her team of junior doctors, also with the aim of assessing the patient’s condition and progress and evaluating the current treatment plan.

1.4 The ‘Education round’
The ‘Education round’ provides education and learning opportunities for junior doctors and medical students, and teaching opportunities and responsibilities for senior doctors. The sample of teaching rounds in Walton et al. (2016)’s data is small (9%, n=4) The challenge for senior doctors is to convey a clear sense of purpose to junior doctors in the consultation (Ker et al., 2009; Abdool & Bradley, 2013), whereas junior doctors are challenged to demonstrate their understanding of disease processes in and through clinical presentations (Shankar, 2013; NSW Department of Health, 2011).

1.5 The ‘Post-take round’
The ‘Post-take round’ occurs when a specialist consultant who is on duty for this purpose, visits patients admitted to the emergency department overnight whose
medical issues fall into the area of his or her specialty, for an initial assessment. This kind of round occurs infrequently in Walton et al (2016)’s data set (5%, n=2/47). The consultant makes an assessment and devises a treatment or management plan for the patient, as well as introducing the patient to the nursing and other staff on duty at the time in the ward. The post-take and consultant rounds may be combined, so that the team visits both new and old patients on the same round (Ahmed, Rutter & Neequaye, 2009; Kirthi et al., 2012).

1.6 The ‘Traditional round’

The ‘Traditional round’ is another rare kind of round, taking up 5% of the data set (n=2/47) that provides patient care whereby it is the junior doctor’s responsibility to examine the patient, and to collect, review and report test results to the senior doctor (Shankar, 2013). The ‘Working round’ occurs rarely in Walton et al.’s data, occupying 5% (n=2/47), and involves a single doctor reviewing the patient’s condition and making an assessment to be used to inform the ongoing care plan. The frequency of this kind of round is not specified. The ‘Review of ward round’ is the rarest type of round, comprising only 3% (n=1/47) of Walton et al’s data set. A nurse, maybe accompanied by an allied health worker, generally leads this kind of round. Walton et al provide no further information about this kind of round, although it is presumably intended to monitor the condition and progress of patients.

ATTITUDES AND BEHAVIOURS WITH PATIENTS AND FAMILIES

- use of a positive, compassionate, caring and empathic attitude towards patients and their family/careers
- involvement of patients as equals in identification of treatment priorities and in the development of the care plan
- ensuring patient confidentiality, particularly where others are involved in the development of a care plan
- imparting of ‘bad news’ in a compassionate and positive manner
- use of a clinical approach that models and reinforces preventive and prophylactic approaches to health care
- encouragement of patient mastery, including participation in self-awareness and rehabilitation programs
- use of a non-judgemental approach to the assessment of all determinants of illness
- willingness to accede to requests for a second opinion
- provision of constructive and evidence-based advice on complementary and alternative management approaches, when patients wish this.

ATTITUDES AND BEHAVIOURS WITH COLLEAGUES

- preparedness to collaborate with primary carers, other referrers and sub-specialists in the care of patients by providing consultative advice, sharing of care, or accepting ongoing care in the best interests of the patient
- willingness to work in a multidisciplinary team
- use of an independent, assertive, inquiring but nonetheless professionally courteous manner in interactions with subspecialty colleagues
- willingness to share knowledge and skills with colleagues
- fostering of a peer network, and collaborative relationships in the health care system
- provision of reassurance and support to colleagues
- zero tolerance in the workplace of sexual harassment and discrimination
- respect for and acknowledgement of professional contributions of all others in the workplaces, including office staff and employees.

CURRICULUM DOMAINS, THEMES AND LEARNING OBJECTIVES

Each of the curriculum documents has been developed using a common format, thereby ensuring a degree of consistency and approach across the spectrum of training.

Domains

The Domains are the broad fields which group common or related areas of learning.

Themes

The Themes identify and link more specific aspects of learning into logical or related groups.

Learning Objectives

The Learning Objectives outline the specific requirements of learning. They provide a focus for identifying and detailing the required knowledge, skills and attitudes. They also provide a context for specifying assessment standards and criteria as well as providing a context for identifying a range of teaching and learning strategies.
DOMAINS

DOMAIN 1: COMMUNICATION
Theme 1.1: Physician–patient Communication
Theme 1.2: Communicating with a Patient’s Family and/or Carers
Theme 1.3: Communicating with Colleagues and Broader Health Care Team
Theme 1.4: Communicating with the Broader Community

DOMAIN 2: QUALITY AND SAFETY
Theme 2.1: Using Evidence and Information
Theme 2.2: Safe Practice
Theme 2.3: Identifying, Preventing and Managing Potential Harm

DOMAIN 3: TEACHING AND LEARNING (SCHOLAR)
Theme 3.1: Ongoing Learning
Theme 3.2: Research
Theme 3.3: Educator

DOMAIN 4: CULTURAL COMPETENCY
Theme 4.1: Cultural Competency

DOMAINS (Cont.)

DOMAIN 5: ETHICS
Theme 5.1: Professional Ethics
Theme 5.2: Personal Ethics
Theme 5.3: Ethics and Health Law

DOMAIN 6: CLINICAL DECISION MAKING
Theme 6.1: Clinical Decision Making

DOMAIN 7: LEADERSHIP AND MANAGEMENT
Theme 7.1: Self-Management
Theme 7.2: Leadership and Managing Others

DOMAIN 8: HEALTH ADVOCACY
Theme 8.1: Advocacy for the Patient
Theme 8.2: Individual Advocacy
Theme 8.3: Group Advocacy

DOMAIN 9: THE BROADER CONTEXT OF HEALTH
Theme 9.1: Burden of Disease
Theme 9.2: Determinants of Health
Theme 9.3: Prevention and Control
Theme 9.4: Priority Population Groups
Theme 9.5: Economics of Health
Domain 1: Communication

In order to provide high-quality care for patients, it is essential that physicians establish and foster effective relationships with patients and their families, other health care professionals and administrative personnel. To achieve this they must develop and utilise the full range of communication-related skills that will enable them to effectively obtain and synthesise information from, and discuss relevant issues with, patients and their families, professional colleagues, administrative personnel and systems as appropriate. These communication skills will be characterised by understanding, trust, respect, empathy and confidentiality. Effective communication skills will also facilitate their ability to research, evaluate and disseminate information in the broader community. We know that first encounters can have a profound effect on practice; therefore it is important to develop effective communication strategies early on in training.

THEME 1.1: PHYSICIAN–PATIENT COMMUNICATION

Learning Objectives

1.1.1 Apply communication skills to engage and reassure the patient in specific situations including: first encounters, history taking, counselling and breaking bad news

1.1.2 Empower patients and be respectful of their rights in all aspects of communication

Domain 1: Communication (Cont.)

THEME 1.2: COMMUNICATING WITH A PATIENT’S FAMILY AND/OR CARERS

Learning Objectives

1.2.1 Apply communication skills in encounters with a patient’s family (including extended family) and/or carers

THEME 1.3: COMMUNICATING WITH COLLEAGUES AND BROADER HEALTH CARE TEAM

Learning Objectives

1.3.1 Communicate effectively within multidisciplinary teams

1.3.2 Communicate effectively with referring doctors, and when referring a patient to another specialist

1.3.3 Apply communication skills to facilitate effective clinical handover and transfer of care

1.3.4 Communicate effectively with health administration

THEME 1.4: COMMUNICATING WITH THE BROADER COMMUNITY

Learning Objectives

1.4.1 Communicate effectively with support organisations, administrative bodies, governments and others in the wider community

1.4.2 Demonstrate the ability to apply specific medico-legal communication practices
**LEARNING OBJECTIVE TABLES**

The following tables indicate the range of underpinning knowledge and skills associated with each of the specific learning objectives.

---

**Colour Coding**

Colour coding within the tables indicates ‘levels of learning’ for related knowledge and skills. This is a guide only, and learning should occur as and when opportunities arise.

<table>
<thead>
<tr>
<th>Colour</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>Foundation: These are the underpinning knowledge and skills, many of which draw on initial medical training. These will be taught and learned and most likely assessed during Basic Training.</td>
</tr>
<tr>
<td>Tan</td>
<td>Higher Order: These build on Foundation knowledge and skills and may be introduced during Basic Training, although predominantly taught and learned during Advanced Training. These will most likely be assessed during Advanced Training.</td>
</tr>
<tr>
<td>Orange</td>
<td>Extended: This knowledge and these skills will most likely be further developed within the context of Continuing Professional Development (CPD), but may be introduced during Basic Training or Advanced Training if the opportunity arises.</td>
</tr>
</tbody>
</table>

---

**Domain 1: Communication**

**Theme 1.1: Physician-Patient Communication**

**PROFESSIONAL QUALITIES CURRICULUM**

**Learning Objective 1.1.1:** Apply communication skills to engage and reassure the patient in specific situations including: first encounters, history taking, counselling and breaking bad news

**Links:** PQC - 4.1 Cultural Competency; BTC - 1.1.1; 1.2.5

<table>
<thead>
<tr>
<th>KNOWLEDGE</th>
<th>SKILLS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Structure of an effective interview.</td>
<td>Demonstrates the ability to build rapport with the patient.</td>
</tr>
<tr>
<td>Questioning and listening techniques.</td>
<td>Demonstrates the ability to communicate effectively with adolescents.</td>
</tr>
<tr>
<td>Aspects of culture and language, which may affect the communication</td>
<td>Demonstrates active listening by:</td>
</tr>
<tr>
<td>encounter.</td>
<td>• making appropriate eye contact</td>
</tr>
<tr>
<td></td>
<td>• asking open-ended questions</td>
</tr>
<tr>
<td></td>
<td>• attending to verbal and non-verbal cues</td>
</tr>
<tr>
<td></td>
<td>• clarifying information provided by patient</td>
</tr>
<tr>
<td></td>
<td>• clarifying patient’s understanding of information delivered.</td>
</tr>
<tr>
<td>Aspects of condition, illness or medication, which may hinder</td>
<td>Gives feedback to patient in an open and honest way.</td>
</tr>
<tr>
<td>communication.</td>
<td>Uses body language appropriately.</td>
</tr>
<tr>
<td>Aspects associated with age, disability, emotional or mental state which</td>
<td>Uses various questioning techniques to elicit information from the</td>
</tr>
<tr>
<td>may affect the communication encounter.</td>
<td>patient.</td>
</tr>
<tr>
<td>Lay terms for medical jargon.</td>
<td>Demonstrates the ability to overcome obstacles to communication,</td>
</tr>
<tr>
<td></td>
<td>using an interpreter or technology where necessary, to facilitate</td>
</tr>
<tr>
<td></td>
<td>effective communication.</td>
</tr>
<tr>
<td>Identify scenarios where information may be withheld.</td>
<td></td>
</tr>
<tr>
<td>Know complaint and independent review procedures.</td>
<td></td>
</tr>
</tbody>
</table>
### Domain 1: Communication (Cont.)

<table>
<thead>
<tr>
<th>KNOWLEDGE (Cont.)</th>
<th>SKILLS (Cont.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Knowledge of relevant cultural practices, e.g. importance of involving extended</td>
<td>Demonstrates the ability to describe complex medical conditions in a way in which the patient</td>
</tr>
<tr>
<td>family for Indigenous people.</td>
<td>can understand; i.e. pitch language use at the level of the patient.</td>
</tr>
<tr>
<td>Knowledge of relevant translation services and practices.</td>
<td>Demonstrates the ability to convey and discuss information on risks and benefits of tests or</td>
</tr>
<tr>
<td></td>
<td>treatment:</td>
</tr>
<tr>
<td></td>
<td>• express quantitative information clearly and avoid bias</td>
</tr>
<tr>
<td></td>
<td>• put information into context</td>
</tr>
<tr>
<td></td>
<td>• make information real and relevant</td>
</tr>
<tr>
<td></td>
<td>• use multiple formats to increase understanding</td>
</tr>
<tr>
<td></td>
<td>• be open and frank about uncertainty</td>
</tr>
<tr>
<td></td>
<td>• be sensitive and check for understanding.</td>
</tr>
<tr>
<td>Knowledge of the emotional dimensions of communication including counter-</td>
<td>Applies quality and safety guidelines to all communication encounters, including communicating</td>
</tr>
<tr>
<td>transference and emotional involvement.</td>
<td>risk, open disclosure, and obtaining consent.</td>
</tr>
<tr>
<td></td>
<td>Manages time pressures, environment, and personal factors which may affect communication.</td>
</tr>
<tr>
<td></td>
<td>Develops the ability to support a patient in distress, especially when breaking bad news.</td>
</tr>
<tr>
<td></td>
<td>Manages own emotional reaction to information and situations in order to promote effective</td>
</tr>
<tr>
<td></td>
<td>communication.</td>
</tr>
<tr>
<td></td>
<td>Develops the ability to appropriately close a consultation.</td>
</tr>
<tr>
<td></td>
<td>Manages patient follow-up (further consultation and/or written communication).</td>
</tr>
<tr>
<td></td>
<td>Sources further information for patients.</td>
</tr>
<tr>
<td></td>
<td>Maintains accurate, adequate and comprehensible medical records.</td>
</tr>
<tr>
<td></td>
<td>Manages and reflects on patient complaints.</td>
</tr>
</tbody>
</table>
## Domain 1: Communication

<table>
<thead>
<tr>
<th>Theme 1.1: Physician–Patient Communication</th>
<th>PROFESSIONAL QUALITIES CURRICULUM</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Learning Objective 1.1.2:</strong> Empower patients and be respectful of their rights in all aspects of communication</td>
<td></td>
</tr>
</tbody>
</table>

**Links:** PQC – 5.1 Professional Ethics

### KNOWLEDGE

- Right to be involved in decision making to the extent that the patient feels comfortable.
- Knowledge of and access to interpretative services.
- Right to confidentiality, even when using an interpreter.
- Right to be given accurate, appropriate, unbiased information about the risks and benefits of test and treatment options.
- Risks and benefits associated with different courses of action and their degree of certainty/uncertainty.
- Methods for maximising the effective communication with patients of reasoning behind clinical recommendations.
- Legal and ethical requirements for obtaining consent from patients.

### SKILLS

- Identifies patient’s preferred decision making approach to the situation and responds appropriately.
- Identifies level of health literacy in the patient, and helps educate the patient accordingly.
- Identifies and manages communication barriers with patients who:
  - are elderly
  - are adolescent
  - have a different cultural background
  - speak a different language
  - have visual or hearing impairments
  - have a learning disability
  - have poor literacy or numeracy
  - have poor health literacy.
- Applies the legal and ethical requirements for obtaining consent from patients.
- Determines information that is relevant to the patient and conveys this to them in a way they can understand.
- Clearly describes the risks and benefits in the context, and acknowledges any uncertainty.
- Respects patients who withdraw consent.
**Domain 1: Communication**

**Theme: 1.2: Communicating with a Patient’s Family and/or Carers**

**Learning Objective 1.2.1: Apply communication skills in encounters with a patient’s family (including extended family) and/or carers**

<table>
<thead>
<tr>
<th>KNOWLEDGE</th>
<th>SKILLS</th>
</tr>
</thead>
<tbody>
<tr>
<td>The role of the significant other in managing the chronically ill patient.</td>
<td>Identifies significant others, and determines their relationship to the patient and each other.</td>
</tr>
<tr>
<td>Legal and ethical requirements for obtaining consent by family or carer on behalf of patient.</td>
<td>Identifies the role of significant other people and determines the need for these people to be involved.</td>
</tr>
<tr>
<td>Legal and ethical requirements for discussions about health management of the patient with the family or carers.</td>
<td>Obtains consent from the patient to share information with significant others or to have them present.</td>
</tr>
<tr>
<td>The specific issues of confidentiality in this situation.</td>
<td>Obtains a collaborative history.</td>
</tr>
<tr>
<td>How to involve family or carer in an effective interview.</td>
<td>Manages time pressures, environment, and personal factors that may affect communication.</td>
</tr>
<tr>
<td>Aspects of culture and language that may affect the communication encounter; e.g. importance of extended family.</td>
<td>Develops the ability to build rapport with the patient’s family or carer.</td>
</tr>
<tr>
<td>Lay terms for medical jargon.</td>
<td>Manages alternative and conflicting views from significant others.</td>
</tr>
<tr>
<td>Identify scenarios where information may be withheld.</td>
<td>Develops the ability to support a patient’s family or carer if they are in distress, especially when breaking bad news.</td>
</tr>
<tr>
<td>Complaint and independent review procedures.</td>
<td>Manages dissatisfied families or carers.</td>
</tr>
<tr>
<td>The importance of negotiation to enable seeing young people alone.</td>
<td></td>
</tr>
</tbody>
</table>
## Domain 1: Communication

### Theme 1.3: Communicating with Colleagues and Broader Health Care Team

#### Learning Objective 1.3.1: Communicate effectively within multidisciplinary teams

<table>
<thead>
<tr>
<th>KNOWLEDGE</th>
<th>SKILLS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Understanding the impact of legal, policy and ethical considerations in communicating within the team. Understand the role of the team in health care management, including: • knowledge of the skill set and contribution of team members • knowledge of the components of effective teamwork • the barriers to effective teamwork.</td>
<td>Demonstrates the ability to communicate clinical reasoning via case notes, letters, discharge summaries and oral case presentation that facilitate understanding by other clinicians of the writer’s reasoning and intended clinical actions. Manages time pressures, environment and personal factors that may affect communication. Identifies and mediates differences between health care workers, patients and carers. Uses conflict resolution skills to facilitate team interactions. Through effective teamwork: • enhances patient outcomes • sets achievable patient-management goals. Gives clear verbal and written communication. Manages barriers to effective communication within teams.</td>
</tr>
</tbody>
</table>

### Domain 1: Communication

#### Theme 1.3: Communicating with Colleagues and Broader Health Care Team

#### Learning Objective 1.3.2: Communicate effectively with referring doctors, and when referring a patient to another specialist

<table>
<thead>
<tr>
<th>ATTITUDES:</th>
<th>KNOWLEDGE</th>
<th>SKILLS</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Respect patient confidentiality • Respect the role of the referring doctor in patient care</td>
<td>Define the components of an effective referral letter.</td>
<td>Explains referral to patient. Establishes rapport with referring doctors. Interprets information within a referral letter. Recognises information that needs enhancement or clarification. Writes a timely letter containing a clear opinion back to the referring doctor. Writes an effective referral letter.</td>
</tr>
</tbody>
</table>
## Domain 1: Communication

### Theme 1.3: Communicating with Colleagues and Broader Health Care Team

**Professional Qualities Curriculum**

**Learning Objective 1.3.3:** Apply communication skills to facilitate effective clinical handover and transfer of care

**Links:** BTC - 1.2.5 Facilitate Ongoing Care Planning

<table>
<thead>
<tr>
<th>KNOWLEDGE</th>
<th>SKILLS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Describe communication elements required for safe and effective transfer of care between:</td>
<td>Demonstrates skills in:</td>
</tr>
<tr>
<td>• medical professionals within an institution</td>
<td>• mouse and keyboard use</td>
</tr>
<tr>
<td>• inpatient and outpatient doctors</td>
<td>• email and the internet and, where applicable, electronic discharge summaries and prescribing</td>
</tr>
<tr>
<td>• primary and secondary care doctors</td>
<td>• legible handwriting</td>
</tr>
<tr>
<td>• different care institutions</td>
<td>• voice dictation and electronic communication</td>
</tr>
<tr>
<td>• hospital and home</td>
<td>• verbal skills over the telephone and during a handover meeting</td>
</tr>
<tr>
<td>• medical and non-medical caregivers.</td>
<td>• identification of self, date, time on all written communications.</td>
</tr>
</tbody>
</table>

Knowledge of communication factors impacting on continuity of care.

Demonstrates the ability to prioritise and communicate accurately medical problems and disease severity when handing over the care of a patient to a colleague in various clinical situations, including:

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>• end of shift handover</td>
<td></td>
</tr>
<tr>
<td>• outpatient transfers</td>
<td></td>
</tr>
<tr>
<td>• inter-hospital transfers</td>
<td></td>
</tr>
<tr>
<td>• transfers between specialties</td>
<td></td>
</tr>
<tr>
<td>• junior doctor to specialist handovers within a service by telephone.</td>
<td></td>
</tr>
</tbody>
</table>

Demonstrates ability to:

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>• write a discharge plan identifying relevant tasks to be completed before discharge in a timely manner</td>
<td></td>
</tr>
<tr>
<td>• coordinate medical aspects of care with other professionals towards attaining these tasks</td>
<td></td>
</tr>
<tr>
<td>• keep patients and significant others informed of progress towards this plan.</td>
<td></td>
</tr>
</tbody>
</table>
Appendix 3  Ethics Consent and Information forms

In this Appendix, copies of the different information and consent forms signed by patients prior to participation in this research, are shown. These forms are as follows:

3.1  Permission to contact form
3.2  Amendment to Permission to contact form
3.3  Plain Language Statement
3.4  Consent Form

In order to comply with ethics requirements mandating the protection of participant and hospital identity, names of patients and hospital staff have been redacted from all forms have to achieve this.
A3.1 Permission to Contact Form

Permission to contact

Ward____

Clinician Patient Discourse – A Multimodal Investigation

Principal Investigator: [Redacted]

I have been advised that a research study is being conducted at [Redacted] Hospital about how patients and clinicians communicate in a hospital setting.

In completing this form, I give permission for a researcher from the study to contact me to explain the project and what my involvement will be.

I understand that providing this consent carries no obligation for me to take part in the study.

........................................................................................................................................
Name of Participant____ Signature Date

........................................................................................................................................
Staff Member Name & Position Signature Date

Please Fax to:
Clinician Patient Discourse, [Redacted]
or ring [Redacted]
A3.2 Amendment to Permission to Contact Form

HREC Number: 11-26-10-09
Title: Clinician patient discourse – A multimodal investigation

Documents to be presented

Protocol Amendments

<table>
<thead>
<tr>
<th>Version</th>
<th>Date</th>
<th>Change to previous edition and Investigator's comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td>Addition of &quot;Consent to contact&quot; form for use prior to potential participants being approached with offer of participation in the study.</td>
</tr>
</tbody>
</table>

Name of Principal Investigator ........................................................................................................

Signature.............................................................................................................................................

Date...........................................
A3.3 Plain Language Statement

CLINICIAN PATIENT DISCOURSE – A MULTIMODAL INVESTIGATION

PLAIN LANGUAGE STATEMENT

RESEARCH TEAM

(Medical Supervisor)

General Medical Unit

Dr Barbara Kelly (Supervisor/Lead Investigator)
School of Languages and Linguistics
The University of Melbourne
Parkville, Vic 3010
Ph 8344 6986
b.kelly@unimelb.edu.au

Consultant Physician
General Medical Unit

Consultant Physician
General Medical Unit

Ms Alice Rouse
PhD Candidate
The University of Melbourne
School of Languages and Linguistics
Parkville, Vic 3010

Clinician Patient Discourse – A Multimodal Investigation
Version 7
23/7/18
Page 1 of 4
PROJECT: “CLINICIAN-PATIENT DISCOURSE – A MULTI-MODAL ANALYSIS”

Introduction

As an in-patient at Hospital, we would like to invite you to participate in our research project. The aim of the study is to investigate aspects of communication between doctors and patients in hospital settings. It is hoped that the research will show what happens during a ward round consultation in more detail than has been previously known.

Information gained from this research may consequently lead to a better understanding of how to improve the quality of communication between doctors and patients in a setting that is often busy and can be confusing.

What will I be asked to do?

You will be asked to consent to the videotaping of a ward round consultation involving you and your doctor. You will be asked to try to ignore the presence of the cameras and researcher and speak normally to your doctor during the consultation. After the consultation, you will be asked to answer some questions about your discussion with your doctor.

How will my confidentiality be protected?

Your name will not be used if you are referred to during analysis or in any kind of research paper or presentation – pseudonyms will be used at all times. In addition, your face will be masked if it is shown during presentations of results at professional conferences or at other public venues. This device will also be used in publications of the results, for example, in journal articles.
Recorded material containing your image and transcripts (which will not contain your name, as explained above), will be stored in a secure location at all times, and during the course of the study, it will only be seen by members of the research team.

How will I receive feedback?

Once the thesis arising from this research has been completed, a brief summary of the findings will be available to you on application to Ms Alice Rouse, c/- [redacted]. It is also possible that the results will be presented at academic conferences or in relevant journals.

You will receive a written summary of results if you express a wish to do so. This will be sent, as a hard copy, to an address you nominate.

Will participation prejudice me in any way?

Please be advised that participation in this study is completely voluntary. Should you wish to withdraw at any stage, or to withdraw any unprocessed data you have supplied, you are free to do so. It is your decision to participate or not, or to withdraw, and we would like to assure you that this will have no effect on any medical or other treatment you may receive in future.

Where can I get further information?

Should you require any further information, or have any concerns, please do not hesitate to contact any of the researchers on the numbers given above. Should you have any concerns about the conduct of the project, you are welcome to contact the Executive Officer, Human Research Ethics, The University of
Melbourne, on ph 8344 2073/Dr Neomy Storch, ph 8344 5208, or [blank].
[blank] Human Research Ethics Committee, ph [blank].

How do I agree to participate?

If you would like to participate, please indicate that you have read and understood this information by signing the accompanying consent form and returning it in the envelope provided. The researchers will then contact you to make further mutually convenient arrangements for participation in the study.

Future research

It is possible that, if you agree, the data collected for this study could be kept on completion of the statutory five (5) year period referred to above, and used for further research, and associated conference presentation and publication.

If you agree to allow the researchers to retain the data collected for this study for use in later research, all measures outlined above to protect your privacy will also apply. Your name and recognisable image of your face will not be used in published or publicly presented material.

You may agree to allow the only the present researchers to use this data for future research, although they do not presently know what its scope or nature might be.
A3.5 Consent Form

THE UNIVERSITY OF MELBOURNE
SCHOOL OF LANGUAGES AND LINGUISTICS

Consent form for persons participating in a research project

CLINICIAN PATIENT DISCOURSE – A MULTIMODAL INVESTIGATION

Name of participant: ____________________________________________________________

Names of investigators:

Dr Barbara Kelly, Department of Linguistics, University of Melbourne,

Mrs Alice Rouse, PhD candidate, University of Melbourne,

Dr [Redacted], Consulting Physician, [Redacted] General Medical Unit,

[Redacted], Consulting Physician, [Redacted] General Medical Unit,

1. I consent to participate in this project, the details of which have been explained to me, and I have been provided with a written plain language statement to keep.

2. I understand that after I sign and return this consent form, it will be kept by the researchers.

3. I understand that my participation will involve an observation and interview, and I agree that the researcher may use the results as described in the plain language statement.

I acknowledge that:

1. I have been told that in the course of this study, the routine ward round consultation which is a normal part of my hospital treatment, will be videotaped. Following the ward round consultation with my doctor, I will participate in an interview, which will be audiotaped.

2. I have been informed that I am free to withdraw from the project at any time without explanation or prejudice and to withdraw any unprocessed data I have provided;

3. The project is for the purpose of research;
5. I have been informed that, with my consent, the observation and interview will be videotaped, and I understand that the resulting videotapes will be stored at the University of Melbourne and will be destroyed after five years, unless I specifically agree for it to be kept for a longer period;

6. My name will be referred to by a pseudonym in any publications or conference presentations arising from the research.

7. My face will be masked in any images that may be part of publications or conference or other presentations arising from this research.

8. I have been informed that a summarized copy of the research findings will be forwarded to me, should I request this.

9. I have been informed that, subject to my agreement, data from this study may be used for later research. In this case, my privacy and identity will be protected by the means described above. The scope and nature of such possible additional research has been outlined to me in a way I could understand.

THIS PROJECT

I consent to this medical consultation being videotaped  □ yes □ no

I consent to this interview being audiotaped  □ yes □ no

Participant signature: __________________________________________

Full name (block letters): __________________________________________

Date: __________________________________________

FUTURE RESEARCH

I consent to data from this study being available for use only in this study
☐ yes  ☐ no

I consent to data from this study being used by the present researchers for later research, presentation and publication in addition to this study if confidentiality provisions described above are adhered to and if the exact nature and scope of such research is described to me.

☐ yes  ☐ no

I consent to data from this study being used by unknown researchers for later research, presentation and publication in addition to this study if confidentiality provisions described above are adhered to although the exact nature and scope of such research is not presently known.

☐ yes  ☐ no

I consent to data from this study being used by unknown researchers for later research, presentation and publication in addition to this study if confidentiality provisions described above are adhered to although the exact nature and scope of such research is not presently known.

☐ yes  ☐ no

Participant signature: _______________________________________________________

Full name (Block letters): ___________________________________________________

Date:

I would like to be sent a summary of the final report findings on completion of the project.

☐ yes  ☐ no

If yes, please nominate a name and address you wish the summary to be sent to:

Participant name (BLOCK LETTERS): _________________________________________
Appendix 4  Ward layouts

The interaction space in all consultations in this study is a hospital ward, but the design and layout of the wards where the consultations take place varies. The four-bed ward is described in the body of the thesis, as it is the most frequently occurring room type in this data (§3.5.3) and the consultation space is discussed here with particular reference to private room and two-bed shared wards.

Private rooms

Nearly a third of consultations in this study occurred in private rooms (31% or 15/48), making this the second most well represented ward type in this data. Private rooms are where there is a single bed in the main room, with an attached ensuite bathroom. These rooms are quite spacious, with windows overlooking the area outside the hospital, and one or two armchairs available for visitors and/or the patient to use. In these rooms, there is plenty of space for doctors and other participants to stand around the bed or to sit on a chair if they wish, for example, to make notes in the patient’s record charts. These rooms are also private spaces where there is a door into the corridor which can be closed, ensuring that conversation cannot be overheard by those outside the room.

The bed in the private room is invariably placed with the head against a wall, perpendicular to the entrance of the room. The bed is flanked on either side by single drawer-and-cupboard units, set on castors, and has a raised tray structure or mobile tray table that fits over the bed, supported by enameled steel tubular frames and set on castors. Most rooms have one or several shelves mounted on the walls above the bed and extending to either side, often with a TV set into them. There is a TV in all rooms.

The basic layout of a single room is shown, schematically, in Figure i below:
Figure i  The interaction space in a single room
(not to scale)
Shared wards – general comment regarding ambient noise

Most consultations (69% or 33/48) in this study occur in shared wards. Of those, most occur in four-bed wards (48% or 23/48), and less than a quarter take place in two-bed wards (21% or 10/48).

When data was collected from beds located in shared wards, particularly in four-bed wards, occasionally noise emanating from outside the interaction space intruded into the data, affecting the audibility of speech to both participants and researcher. Interaction spaces surrounding patient beds in shared wards can be separated from each other by heavy cotton curtains drawn around each bed and its immediate surroundings along a curtain rail indicated in the sketch plans in Figures 5 and 6 (below) by dotted lines. However, this separation provides visual but not aural isolation from adjacent areas, thereby providing only a measure of privacy to the patient (as well as to doctors) during the consultation.

Two-bed wards

Two-bed wards are organized with a shared bathroom by the entrance to the room beyond which are two adjacent beds each flanked by a mobile tray table, a chair (usually but not always), a bedside chest of lockable drawers, and a TV suspended from the ceiling above the bed. A curtain rail ran around the space allocated to each bed allowing a heavy cotton curtain to be drawn when privacy is required for the patient. A diagram of the layout of this kind of ward is shown in Figure ii below.

Because there are fewer patients in the ward, there is consequently less movement of patients, visitors and staff around patients’ beds, and less associated noise from talking, television sets, tea trolleys etc. with the result that this kind of ward is noticeably quieter than larger wards.

On the other hand, because there is less background ambient noise, there is arguably less privacy from an aural perspective during conversations with visitors or doctors. This is because patients’ individual spaces are small, beds are close together. Therefore, the setting is more intimate, but in some ways less private.
Figure ii: The interaction space in a two-bed ward
Not to scale
Appendix 5  

Transcription Key

The following summary shows the symbols used in transcriptions to represent features of interaction in this study. They are based on the transcription system developed by Gail Jefferson and developed over time. This list is taken from the summary in ten Have (2007:215-216).

All names used in extracts in this study are pseudonyms (see §3.5). For example: ‘Melissa’ (C28), ‘James Smithers’. (Extract 55).

Sequencing

[ A single square left bracket indicates the start of a section of overlapping speech.
]

A single square right bracket indicates the closing of a section

= An equal sign at the end of one line and the start of an adjoining line indicates two utterances with no gap between them but which are not overlapping.

A capital letter at the start of a speaking turn indicates that it is a new turn.

Timed intervals

(0.0) Numbers in single brackets show a period of silence, timed in tenths of a second.

(.) A full stop enclosed in single brackets indicates a micropause between utterances.

Characteristics of speech

Word Underlining shows emphasis or stress placed on a word or part of word.

:: Colons indicate points where the sound in an immediately prior sound is prolonged. The longer the period of prolongation of the sound, the more colons are used.

- Dash indicates a word cut off.

? Question mark indicates rising intonation.

. Full stop indicates falling tone.

, Comma indicates continuing intonation.
WORD Upper case indicates a word that is loud relative to the surrounding words.
○ Indicates talk that is quieter than the surrounding talk.
< Right and left carets indicate a section of talk that is faster than the surrounding talk.
.hhh Full stop preaced row of lower case h’s indicates an inbreath.
hhh row of lower-case h’s indicates an outbreath
w(h)ord Indicates breathiness, as when there is crying or laughing etc.
heh heh heh. Indicates laughter

Uncertain words and comments, as well as descriptions of embodied action
( ) Empty brackets indicate speech that is un-decipherable. The distance between the brackets indicates the duration of the speech.
(word) Words within brackets indicate the transcriber’s best guess at unclearly articulated words.
(( )) Double brackets indicate transcriber’s descriptions, e.g. of embodied action.
MG Indicates mutual gaze (i.e. when two participants are looking at each other)

Source: ten Have, 2007

Detailed examples of a selection of characteristics of speech outlined above.

Overlapping speech
Overlapping speech is when two or more participants speak at the same time, so that their utterances overlap. When this occurs, it is represented on the transcript by square brackets that are aligned, vertically, on adjacent lines in the transcript, at the points where the overlapping speech begins and ends. For example:

Extract 1A Overlapping speech

1 Nancy oh ril[ly I’m ’nna go loo:k,]
2 Hyla [in the View section ]

Source: Hepburn & Bolden (2014:59)
Silence and pauses

Silence and pauses frequently occur within and between turns during interaction. Episodes of silence are indicated on the transcript by brackets that are inserted at the location of the silence. The duration of the silence is indicated either by a full stop (.), which means ‘a short pause’, or by numbers indicating the fraction of a second in tenths of a second that the silence lasts, that is indicating a longer pause and showing its duration. For example: (0.3). Examples of the representation of silences and pauses are shown below.

Extract 2A  Silence and pauses

85  MR  eh:: I think they’d- they’d have to share it if
86     (0.6)
87  MR  gatherin’ information
88  IV   .hhh okay:? So:: how confident are you that (. ) they::

Source: Ten Have (2007:185, Wisconsin Survey 02)

In my transcripts I mark pauses as well as longer periods of silence (‘gaps’) on separate lines because I think it shows the interactional pattern of speech more clearly, and it also provides space to mark any relevant co-occurrence of embodied action in the pause in conversation when it occurs. This in turn is a way that I find makes it easier to show the interplay of different modes of action.

Laughter

Laughter is described as being a “feature accompanying talk” (Hepburn & Bolden, 2014:66), and it plays an important role in interaction, including in medical discourse (Haakana, 2001; Glenn, 2003; Glenn & Holt, 2013; Hepburn & Bolden, 2014). Laughter in interaction was described in detail by Sacks, Schegloff & Jefferson (1974; Sack, 2004) and its detailed transcription is complex as it can reflect the particular vowels within aspirated laughter particles, including: “huh/hah/heh/hih” (Hepburn & Bolden, 2014:66). Transcription can also capture the exact location of laughter in an utterance, for example when it occurs through speech, at different volumes or in terms of voice quality, sometimes described as a smiling voice.
Interactional functions of laughter are explored by, and its representation in a transcript articulated by Jefferson (1984; 1985; 2004). Its uses in interaction are also described in research by the authors listed above. In this study laughter is not a primary focus of the research, so it is represented in a way that is indicative rather than fully articulated as many of the researchers named above do. In this study, I represent laughter as follows: ‘heh heh heh’, with ‘heh’ representing a burst of laughter, and the number of bursts indicating the duration of the episode of laughter. An example of the transcription of laughter, given by Jefferson, Sacks and Scheglof (1977:4) is shown below:

Extract 3A  Laughter

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Ruth</td>
<td>what’s his name. Who played in- Goodbye Mister Chips.</td>
</tr>
<tr>
<td>2</td>
<td>Lori</td>
<td>mm hm.</td>
</tr>
<tr>
<td>3</td>
<td>Bill</td>
<td>Peter O’Toole.</td>
</tr>
<tr>
<td>4</td>
<td>Ruth</td>
<td>Pwiter O’Toole, fer that [picture.</td>
</tr>
<tr>
<td>5</td>
<td>Bill</td>
<td>[wuhh</td>
</tr>
<tr>
<td>6</td>
<td>Ben</td>
<td>“Pwiter O’Toole.” [</td>
</tr>
<tr>
<td>7</td>
<td>Bill</td>
<td>[.hh hh [heh heh ]</td>
</tr>
<tr>
<td>8</td>
<td>Ruth</td>
<td>[ehh heh heh]</td>
</tr>
</tbody>
</table>

Source: Jefferson, et al. (1977:4, Schenkein:II:64)

Emphasis and intonation

Sometimes a speaker uses changed intonation to emphasize part of a word or utterance, or to mark a word or utterance as a question with a final interrogative rise of tone (see Example 4 below). When this happens, it is shown in the transcript by underlining of the word (for emphasis), words or part of the word where this emphasis occurs, or by the use of a question mark (indicating a final rise) or comma (for a less pronounced final rise). Alternatively, a full stop is used to indicate a final fall in intonation. For example:

Extract 4A  Interrogative intonation marking declarative questions

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>You paid them already?</td>
</tr>
<tr>
<td>2</td>
<td>You’re going?</td>
</tr>
</tbody>
</table>

Source: Stivers & Enfield (2010:2)
Extract 5A  Showing points of emphasis: medical clinic discussion

1  Mrs N    while we’re on my gut.
2  Dr D    yes
3  Mrs N    a couple a weeks ago: hh u:m (0.6) I had (.I tremendous
amount of rectal pain

Source: Teas Gill & Maynard (2006:118)

Lengthened vowel sounds

When vowels in a word or utterance are lengthened, this is indicated by the insertion in
the transcript of one or more colons at the point where this occurs. For example:

Extract 6A  Lengthened vowel sounds I

908 patient    that’s all ah’m good for.
909 (0.4)
910 patient    [a::n’ uh-
911 doctor    [in your perception.
912 (.)
913 patient    hunh?
914 doctor    your perception


Extract 7A  Lengthened vowel sounds II

81 IV    so:: do you think the census bureau keeps the information that
82 people give them? Do you think they keep that private?

Source: Ten Have (2007:185, Wisconsin Survey 02)
Appendix 6 Sample Consultation Transcription

KEY

The consultation transcript (below) has been colour-coded for consultation phase. Orange represents the opening, blue represents the consultation core, and purple represents closing. Participant coding is as follows:

D = doctor (junior doctor/registrar),
P = patient,
S = student,
D1 = second doctor (senior doctor/consultant);
D2 = 3rd doctor (senior doctor/consultant).

Extract 8A  Full transcript of Consultation 48 (C48) – Appendix 6

OPENING

Becoming co-present/entry

1   ((Medical team arrives))

Greetings and confirming patient identity

2 D  Morning Melissa= ((P lying facing entry to consultation space))
3 P  Ha:lo: (0.1)((medical team enters space))

Howareyous/pleasantries

4 D  How are you this morning ((P starts to roll to face towards D))

Settling in & howareyous/pleasantries

5 D  Brian just grab the curtain.
6 .(0.1)((Brian, junior doctor, pulls curtain around bed))
CONSULTATION CORE

Opening business

9 D You feeling well?= 
10 P Yes, ((turns to look at D; MG synchronized with 'well'))
11 P [I need] to go home ((smile))
12 D [good ]
13 D (.)

Gathering information: Verbal examination

14 D No fevers sweats ((MG))
15 P No
16 P (0.1)((P headshake))
17 D No chills
18 P .((P headshake))
19 D Shaking
20 P .((P headshake))
21 D Nausea vomiting
22 P .((P headshake))
23 D No [( illl fill)]((P headshakes))
24 P [I wouldn't ] tell you anyway ((smiles))
    [huh huh huh]
25 D [huh huh huh]
26 D (.)

Providing feedback

27 D oka:y ((looking at notes))
Gathering information: Physical examination

D Neo:le:ts ((putting notes on table))

D see the leg ((D & P look at leg, P starts to remove sheet covering leg))

D (0.5) ((D walks to bed and helps P uncover leg))

D okay ((Looks at leg))

P it feels better today than it has been ((looks at D))

D Its certainly no worse ((turns to look at P = 'worse', MG))

P [yeh no ] ((MG = 'no', shakes head ))

D <I'm just going 'n compare it> to the other side ((D & P look at the leg))

D (0.3) ((examines other leg; D looks at leg, P looks away))

D What about the pain?

D yeah? ((D looks at leg, P looks away, smiles at other D with D's 'yeah')

P .(0.2) ((P looks away))

D both sides are equally warm there ((D looks at leg, P looks at D with

D 'both sides'))
D .(0.2)((D continues to examine leg, D & P look at leg)) and
D (.)((looks at P))((external noise))
P Thats not too bad((eyebrows up, head nod, MG))
D Oh! You're actually able ter (.)((looks at P, smiles))
P Touch it ((MG, repeated head nods and smile))
D Yeah! Yeah tha tha (.)
D thats
D2 Its the same one

Greetings
((another senior doctor arrives))
D1 Hi Melissa ((D stops examination and stands up))
P Hello ((looks at D1, eyebrow flash and smiles))

Introductions
D You
D (.)
D you've met
D (.)
D Dr Roberts ((puts hands together in front of body in cupped gesture)) before?=
P Yes::
P (0.2)((smiles, looks at D2))
D Okay
P (.)) ((turns back to look at D))

Providing feedback and (informal) case presentation
Gathering information: physical examination

81 D1 Has it? ((P looks at D1, nods repeatedly, wide open eyes))
82 P It feels ** much better ((looks at D1))
83 D1 Oh wow ((P looks at leg, D1 leans in to examine leg))
84 D1 .(0.2)((D1 examines leg))
85 D1 now you couldn't tolerate you doing that ((examining leg. D looks at D1))
86 P Nuh ((looks at leg))
87 D And we're a:febrile (0.3)((looks at D1))
88 D and systemically feels [well ] ((P turns to look at D))
89 D1 [Shrink]ing a little bit more too we only marked
90 D1 that [yes ]terday ((looking at leg))
91 P [Yeah][(looks at D1)]
92 D1 .((looks at D1))
93 D1 Yeah
94 (.(
Gathering information: verbal examination

95  D  A::nd ((P turns to look at D))
96  D  (.)
97  D  the antibiotics are goin' okay?= ((looking at notes))
98  P  Yep ((looks at D then closes eyes))
99  D  Yeh
100 D  .((looks at P, P looks at D, nods head repeatedly))
101 D1 Not causing you any problems?
102 P  .(
103 P  No= ((looking at D, shakes head))
104 D  No diahhroea
105 P  No
106 P  (.)
107 P  yeah at all
108 D  Yeah
109 D  (.)
110 D  Fantastic
111 D  (.)
112 D2 [Sounds great]

Discharge discussion and making arrangements

113 D  [Okay !(.) ]I think we can let you go home
       ((looks at P, smiles broadly))
114 D  broadly)
115 P  Oh [(may) ] ((P looks at D, blinks smiles broadly))
116 D  [huh huh] huh huh
117 D  .((turns to look at D1))
118 D  Okay
Making arrangements

D we'll need to see you back in the clinic ((MG P nods repeatedly))
D ((turns to look through case notes he's holding))
P ((looks at D, nods))
P Yep
D (0.1) (D looks through notes)
D So
D (0.4) (looks at notes, takes pen from pocket)
D shall we say ((turns to D2))
D1 T'dayz
D1 (.)
D1 aww
D1 (.)
D1 Thursday
D1 (.)
D Yaah
D1 (.) (looks at D1)
D1 What about the
D1 (.)
D1 next.Friday
D1 (.)
D1 [Melissa ]
D1 [Yeah that's] alright ((looks at D1, nods))
D1 Just into the hospital quickly
D (.) (looks at P)
D Is that alright? ((looks down))
PYep
P (0.1) (eyebrow flash, nods head, then sagittal headshake))
That's fine

Treatment discussion/recommendation

We'll give you um (0.1)
Yeyp yeyp ((looks at D1))
Enough

Keflex t' last for the at least ((nods))

uh that'd be::((looks up)) eight days?

Eight days

I'd stay on it

((nods, looks at P))

Oh yeah yeah ((looking at D1, nods))

Until then

and then we'll decide whether to stop or

give you more ((nods))

No: problems ((shifts gaze to D, then back to D1))

Making arrangements

And give us a ca:ll

problems (.)

there's someone on

((nods))

all over Easter obviously

(.)

and then next week so if you have any any
Patient feedback request

188 D Did you have blood taken this morning?
189 P No not [yet]((shifts gaze from D to D1, then back to D))
190 D [No ]
191 D (.)
192 D that's alright that's alright yeah
193 D (0.1)((smiles, waves, starts to leave the space))

Final questions/case presentation

194 D1 She had a really nasty cellulitis
195 D1 (.)
196 D1 see the original markers
197 D2 Yeah
198 D Okay?
199 P How long d'you think that I'll take to get
[Which antibiotics? ]

[Everything done before] I cn go? ((looks at D, D returns to the space, looks at P))

[Oh not long ]

( )

[(          )]

The pharmacist

[Say again?]

[Just needs] to come

(.)(MG, P nods)

and um

[Keflex? ( )]

[Give you all your medications but that shouldn't take long]

(The last batch had more sensitive staph]

[Do they go under ( )]

An hour?

Oh an hour I'd say at leas- an hour

(.)

Yeah

Psssch ((smiles, looks at D))

Let's not be too optimistic ((looking at notes))

Uh huh

(.)

[Do they go under ( )]

[Okay?]

(.)

excellent ]

(1.3)((writing in notes))((loud background noise))

I was going to go home
D1 .(0.2)
D1 (I've kept one for the last help)
S Yeah okay

CLOSING

D1 ((moving toward P)) So <two things before you
D1 go>( )((P turns to look at D1))

Making final arrangements

D1 .((counting gesture))
D1 pick up your antibiotics
D1 .((P nods))
D1 and ah:: an appointment for next
D1 .((counting gesture))
D1 then
P [Fri:day]((P nods, MG))
D1 .(0.1)
D1 yep alrighty
D1 We'll get everything [ready ] ((waves, leaves space))

P [Thank ] you
D1 See [ya ]
P [Excel]llent

DOCTORS LEAVE
Appendix 7  Examples of CA concepts and other interactional features

Actions

These are discussed in more detail in Chapter 3, §3.2.2.1.

In order to illustrate the concept of action, examples of two different actions being accomplished, are shown below, both in the form of questions. These actions are making a request (Extract 1A) and making an offer (Extract 2A). In Extract 12 below, Madeline makes a request for accommodation from her friend’s mother.

Extract 1A  Action: Making a request

07 Madeline: =okay. I was just wondering y’know hhh (0.3) could- (.)
08 d’you think you might (. ) wanna rent (. ) you know like
the 09 bottom part a yer: (. ) g’rage like to me fer a while, °a
10 sump’m like that °
11 °(0.3)
12 Marsha wu[1-
13 Madeline [(I think [              ])
14 Marsha [(I think [              ])
15 Madeline ye:ah

Source: Sidnell (2010:157, (34) Madeline 2)

Madeline makes a request for accommodation from Marsha (lines 07-10). There is a delay in Marsha’s response, which is prefaced by a dispreference marker ‘wu[1- (line 12) followed by a request for clarification and confirmation of Marsha’s understanding of Madeline’s meaning as a request for accommodation. In line 15 Madeline confirms Marsha’s understanding, at which point she has successfully implemented the action of making a request.

Extract 2A  Action: Making an offer

12 Janet: a-> Do you want me to come an’ get her?
13 Anne: Uhm:, it doesn’t matter, like (hñ)
14 (0.4)

Source: Sidnell (2010:60, (2) XTR 1 – Detail)

Extract 13 shows Janet ‘making an offer’ (line 12), which is followed by a qualified refusal in Line 13 from Anne. In this example the action is more directly made and understood as such, although it is not accepted.
Extract 3A  Question/Answer adjacency pair

1  A  What time is it?  Question
2  B  Half-past nine  Answer

From Clift (2016:70)

See §3.2.2.2

Extract 4A  Question and expanded response

1  DOC  and what brings you here to see us in the clinic?
2   
3  PAT  Well my (. ) foot ( 1.0 ) uhm ( 1.0 ) I was here on
4   
5  DOC  =Mmkay
6  PAT  It’s actually a follow up
7  DOC  Yeah I read over your report uh: that they dictated
8   
9  from the emergency room on Sunday


Extract 5A  Preferred response

1  Kim:  An’ you can have that one.
2  Mark:  You don’t like=want thuh green one?
3  Kim:  -> No

Source: Stivers & Hayashi (2010: 39, (1) RD)

or, for example:

Extract 6A  Dispreferred response

1  B:  You’re coming to the swim meet on Sunday, aren’t you?
2  A:  Well no, I can’t
3   
4  I have to work on Sunday

In this example, A gives a dis-preferred response (line 2) to B’s request for confirmation that A is coming to the swim meet. The response is marked as dispreferred by its prefacing by the discourse marker ‘well’ (line 2), that projects a forthcoming response that is problematic (Bolden, 2014). The dispreferred response is also followed by an explanation (line 3).

Extract 7A  Self-initiated self-repair

1  H:  This girl’s fixed up on a da- a blind date.

Source: Kitzinger (2014:230, Hyla & Nancy)
In Extract 17 above, Hyla corrects her announcement in Line 1, mid-utterance, by elaborating her representation of the kind of outing ‘the girl’ is going on (is ‘fixed up on’) from a ‘da[te]’ to a ‘blind date’. The repair is done before Hyla has finished fully articulating the word ‘date’ (although late enough that the word is recognizable as such) and restates it as ‘a blind date’.

**Extract 8A  Other-initiated self-repair**

1 Chl: Are they getting married.
2 (0.5)
3 Pau: Who.
4 Chl: Tim an’ Dave.
5 Pau: They’ve bought a house together now?.

Source: Kitzinger (2014:231, Land:YU09)

In this example (Extract 18 above), Chl is prompted to elaborate the question posed in Line 1 about whether ‘they’ are ‘getting married’. In Line 3, Pau displays an insufficient understanding of the question to be able to respond relevantly by asking Chl for clarification about the identity of the people being referred to in the question. When Chl provides the requested clarification, thereby repairing the original question in this way, Pau is able to produce a response in Line 5 that incidentally completes an embedded adjacency pair.

**Extract 9A  Activity: Doing introducing**

In the extract below (Extract 14) when Olexa arrives at an (American) university sorority breakfast, accompanied by someone unknown to those already at the breakfast, she introduces her companion:

01 Kelsey: Hey Olexa,
02 Olexa: [Hello, huh huh huh
03 Trish: Hi:a[y,
04 Olexa: [Thisiz my little brother.hheh!
05 Jenel: Oh wo[:w hi::
06 Trish: [Hi:],
07 Sher: [Hi:ee

Source: Pillet-Shore (2011:79, Excerpt 1: sorority breakfast g-1 (simplified))
Following the greetings that follow Olexa’s arrival (lines 01-03), Olexa introduces her companion (line 04). The introduction, which consists of Olexa announcing her companion’s identity in terms of his relationship to her (her brother), with a following outloud “hheh!” is followed by a series of greetings from the pre-present ‘sorority sisters’, Jenel, Trish and Sher (lines 05-07).

Extract 10A    Showing proxemics/movements in space
1   ((knock))
2   Dr come: in:
3   (4.6)((P enters the consulting room))
4   Dr do sit down
5   (5.5)
6   Dr what’s up?


Extract 11A    Showing body movement/posture shift
1   Mum Kath’rine >c’you move<
2   [ a[long] a littw bit ple[ase ] =
3   Mum [((pu[shes] Anna’s chair next [to Katherine)])] =
4   Kath =[((swings legs round to block chair)])
5   Kath =[I’wn- I wanna sit [on my oh:::

Source: Hepburn & Bolden (2014:70, Crouch 020.15)

Extract 12A    Showing gaze shifts
37   A two two:: the standing bidder (0.2) last chance ((glances at B3))
38   (0.2)two thousand two hundred pounds::: (0.6)[knock]

Source: Heath & Luff (2014:292, Transcript 2)

Extract 13A    Showing head nodding to bid at an auction
This action is shown in a transcript using bracketed comments in Example 11 (below). In this example, head nodding at Line 5 is taken as constituting a bid at the auction underway. Because in my transcripts I use double brackets, I have changed the original square brackets (in Heath & Luff, 2014) to double brackets for the sake of a clearer demonstration of how I transcribe head nodding (from Heath & Luff, 2014:292):

Extract 14A    Showing head nodding to bid at an auction
1   A lot one hundred and six. There it is lot one hundred and six
Discourse markers

Discourse markers are a somewhat ill-defined category of “linguistic devices” (Bolden, 2014), often single words that occur at the start of a turn or between actions, such as: well, oh, so, like, anyway, you know, uh, and that fulfil a range of interactional functions. Bolden (2014) groups these functions into the following broad categories: “indicating contiguities and disjunctions between interactional units [including by the way, hey, listen, look, now, okay, oh]...conveying stances vis-à-vis prior actions [such as well, uhh and oh]...[and] facilitating turn taking [such as mm hm, yeah, right, oh - backchannel responses or change of state tokens]” (Bolden, 2014:5).
Author/s: Rouse, Alice Ann

Title: The hospital bedside consultation: doctor-patient interaction

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