

Naturally Occurring Interactions and Guidance Codifications in Healthcare Communication Analysis: the Case of Praising Obese Patients

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Abstract: Studies of face-to-face communication illuminate the ways in which the conduct and outcome of healthcare encounters is contingent on the interactions that occur within them. Work in this field benefits from the increasing availability and acceptance of recording technologies for data collection, enabling the production of richly detailed investigations of real-time healthcare communication. At the same time the growing interest within healthcare professions in inter-personal communication has lead to codification of interactional practices in guidance and training documents. This article argues that the intersection of these two developments presents a significant opportunity for fruitful research: analyses of naturally occurring communication in consultations can take the interactional practices prescribed in guidance and training documents as a topic or starting point for investigation. The subsequent results enhance empirical and conceptual knowledge whilst also offering a commentary on the guidance prescriptions. To demonstrate this, the article reports on a conversation analytic investigation of compliments in specialist obesity consultations prompted by guidance recommending the praise of these patients 'every opportunity'. The findings reveal that the actions of praise-giving and response are interactionally complex in this kind of setting and closely associated with certain institutional and normative dynamics, thereby the guidance is less straightforwardly positive than it at first appears. By advancing analytic understanding and offering practical implications this kind of approach makes a substantial contribution to the interpersonal level of healthcare communication analysis.

Keywords: *Healthcare communication, naturally occurring interactions, conversation analysis, obesity.*

Introduction

Studies of face-to-face communication explore the interactions (both spoken and non-verbal) that occur between participants in a setting. This kind of work enhances understanding at

the interpersonal level of healthcare communication analysis and illuminates a crucial component of healthcare delivery. The social sciences have long taken an interest in face-to-face communication between practitioners and patients in healthcare

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encounters, and in recent years this field has grown in size and scope. In particular the development and acceptance of recording technologies enables naturally occurring interactions to be collected and scrutinised to an increased degree of detail. The findings produced illustrate the ways in which the conduct and outcome of healthcare encounters is contingent on the communication that occurs within them, plus the ways in which this communication may resonate with broader societal dynamics. At the same time, healthcare training and policy has also increased its focus on face-to-face communication, with guidance documents often specifying practices to be adopted by practitioners when interacting with patients. This article argues that the intersection of these two developments presents a significant opportunity to enhance the study of health and communication. In-depth analyses of naturally occurring, 'real time' communication in consultations can take the interactional practices prescribed in healthcare guidance as a topic or starting point for investigation. The results enhance empirical and conceptual knowledge whilst also offering a commentary on those guidelines and thus providing practical implications. To demonstrate this, this article draws on data collected in specialist consultations for the treatment of obesity and examines them in relation to a single piece of guidance promoting the praise of patients 'at every opportunity'. Analysis reveals that actions of praise-giving and praise responses are interactionally complex and closely associated with the particulars of the institutional setting and the dynamics

of obesity healthcare. Consequently the prescription to praise at every opportunity is less straightforwardly positive than it might at first appear.

Background: Naturally occurring interactions and guidance codifications in healthcare communication analysis

The interest taken within social research in face-to-face communication in healthcare has grown since the 1960s (for overviews see, Roter and Hall, 1992; du Pre, 1999; Heritage and Maynard, 2006b). Much early social scientific work in this field – such as seminal studies conducted by Balint (1964), Stimson and Webb (1975), and Byrne and Long (1976) – used observational, interview and survey methods to describe and discuss the ways in which primary care physicians speak to their patients. Since then, the field has grown in a number of ways (see overviews cited above). It has incorporated a broader range of philosophical, methodological and analytical perspectives, and acknowledged the interactional role of the patient in the medical encounter. Furthermore, a wider range of healthcare contexts have been investigated, such as nurse-patient interaction (Candlin and Candlin, 2003; Jones, 2010), parent-practitioner interaction (Meeuwesen, Bensing and Kaptein, 1998; Stivers, 2007) health visiting (Heritage and Sefi, 1992), counselling (Peräkylä, 1995), secondary care clinics (Silverman, 1987) and hospital settings (Oakley, 1980). These studies highlight the central role of communication in achieving key consultation tasks such as

history-taking, examination, diagnosis-giving etc. They also highlight the alternative interactional resources available to participants and the consequences this has for discussion, negotiation and decision-making in the consultation (Bloor, 1976; Silverman, 1987). In addition they illuminate how interactions may differ according to the task being accomplished, the specifics of the setting and the identities of those present (Oakley, 1980; Ong et al., 1995; Heritage and Maynard, 2006a) whilst also revealing what is generic, regardless of changes in setting and personnel (Strong, 1979; ten Have, 1989). The growth of the field in this way has enhanced a broad range of academic disciplines – amongst others: sociology, social psychology, applied linguistics and pragmatics – as well as interdisciplinary initiatives such as the journal *Patient Education and Counseling* and the International Conference on Communication in Healthcare. It has also contributed to on-going debates regarding power and asymmetry, profession, lay and expert knowledge, gender, socio-economic status and ethnicity.

A particular benefit to this field has been the increasing availability of recording equipment for data collection and its growing acceptance by ethics committees, research gatekeepers and research participants (Heath, Hindmarsh and Luff, 2010). Audio or video recording the consultation avoids reliance on note-taking and memory recall and enables the captured interactions to be played again and again after the event. This enhances the accuracy of coding schemes and transcripts (Peräkylä, 1997) and enables those codings/transcripts to be

reviewed by groups of analysts as well as individuals so that complexities in the analytic process can be opened for discussion (Silverman, 1993; Jordan and Henderson, 1995). The fundamental analytic benefit of using recordings in studies of face-to-face healthcare communication is that they produce rich data of naturally occurring interactions and thereby enable detailed scrutiny of the ‘real time conversations’ on which these encounters are based (Pilnick, Hindmarsh and Gill, 2010). For instance the detailed analysis of naturally occurring interactions enables an understanding of how intricacies such as the particular wording of a question or instruction from the practitioner is contingent to the subsequent answers produced by a patient or the conduct of a physical examination (Roter and Hall, 1992; du Pre, 1999; Heritage and Maynard, 2006b). Current studies take up this opportunity to produce detailed, real-time analyses of face-to-face encounters using a variety of methodological approaches including process analysis, such as the Roter Interaction Analysis System (Roter and Larson, 2002), discourse analysis and applied linguistics (e.g., Candlin and Sarangi, 2011), and ethnomethodology and conversation analysis (e.g., Pilnick, Hindmarsh and Gill, 2009).

The capacity for research to produce these detailed, intricate analyses of naturally occurring face-to-face interactions coincides with an increased awareness and codification of communication within healthcare training and guidance. Whereas communication was once a matter of relatively small interest within the profession, a consensus has emerged

emphasising the importance of ‘good’ communication for the delivery of ‘good’ healthcare (Bensing, van Dulmen and Tates, 2009). In large part this interest has been influenced by the kinds of academic studies discussed above and developed into conceptual models for practical application. For instance Byrne and Long’s (1976) observational study of general practice played a key role in calls for a ‘patient centred approach’ in the consultation. This approach acknowledges the patient’s experiences and perspectives and has become widely promoted across healthcare (Moore, Wilkinson and Rivera Mercado, 2004). This heightened interest in face-to-face communication in healthcare training and guidance has led to an increased codification of how it should be done (Armstrong, 1984). Policy and training documents frequently specify precise forms of interaction to be adopted in the pursuit of ‘good’ communication. For instance, codifications of ‘patient centredness’ frequently prioritise open ended questions over closed ones, which require a simple yes or no response, since they encourage patients to report their concerns at length (Moore, Wilkinson and Rivera Mercado, 2004).

The coincidence of the detailed specification of ‘good’ communication in healthcare training and guidance with the advances in social research enabling naturally occurring interactions to be scrutinised in detail promotes opportunities for novel research. Empirical analyses of interactions between practitioners and patients can advance academic understanding whilst at the same time provide a commentary on guidance

prescriptions. This is demonstrated by Peräkylä and Vehviläinen (2003), who describe the conceptually based prescriptions of interaction found in healthcare guidance texts as ‘stocks of interactional knowledge’ (SIKs) underpinning professional understanding and governance. They argue that the results of academic studies can provide insightful commentaries on SIKs; they can highlight and possibly falsify the assumptions underpinned in a conceptual model of interaction, provide a more detailed description of the types of interactional practices that have been codified and potentially add a new dimension to understanding these practices. Peräkylä and Vehviläinen use findings from existing conversation analytic studies to illustrate this. They demonstrate, for instance, that the use of yes/no questions by a practitioner is not necessarily incompatible with the patient centred approach since they may be appropriate to the particular context and phase of the consultation and do not necessarily prevent patients producing expanded answers. This paper argues that in addition to using the results of existing analyses of naturally occurring interactions to reflect on prescriptions set out in healthcare guidance, these prescriptions can be drawn on as a topic or starting point for analysis itself. Analysis can then both advance our understanding of healthcare communication and provide insights relevant to the use of these prescriptions in practice. To demonstrate this, the remainder of this paper reports on a piece of analysis initiated by a single healthcare recommendation. As described below, the recommendation and the data analysed concern face-to-face

interactions in the specialist treatment of obesity.

Methods and data: the case of praising obese patients

Obesity is a chronic health condition caused by an excess of body weight, specifically body fat, and associated with a variety of co-morbidities, including joint problems, heart disease, certain forms of cancer and type 2 diabetes (World Health Organisation, 2000). Treatment requires the patient to lose weight, often through diet and exercise regimes and perhaps supported by pharmaceutical interventions and bariatric surgery. As the prevalence of obesity has become regarded to have reached epidemic proportions across the globe (Mokdad et al., 1999 and 2000; World Health Organisation, 2000) it has received an increased level of interest from governments and healthcare organisations. Social science research frequently argues that this interest stems not only from the existence of obesity as a health problem but also as a consequence of a cultural distaste of fat. Analysts have argued that an obese body is devalued in contemporary society as it is taken to have been caused by – and to symbolise – laziness, greed and an absence of self-control (Bordo, 1993; Sobal and Maurer, 1999). It is also argued that scientific and regulatory representations of obesity are driven by ideological positions as much as empirical ones, prioritising the ideal ‘thin’ body, oversimplifying uncertainties within obesity science, and overlooking the rights of the ‘fat’ individual (Gard and Wright,

2005; Rothblum and Solovay, 2009). Consequently healthcare policies emphasise the requirement for obese individuals to take responsibility for their condition and to make an effort to become well, overcoming their normatively disapproved of characteristics whilst also losing weight (Evans, Rich and Davies, 2004; Jutel, 2006). Existing studies (eg., Throsby, 2007; Webb, 2009b) suggest that individuals who have undertaken medical treatments for obesity attend to these moral prescriptions to some extent, distancing themselves from implications that normatively disapproved of behaviours may have led to their weight gain and displaying their personal commitment to and effort in weight loss.

The data discussed in this article were collected as part of a wider project (Webb, 2009a) on practitioner-patient interactions in specialist obesity clinics. Fieldwork took place in two UK hospital outpatient clinics specialising in the treatment of obese adults and run by one hospital consultant. Patients are referred to the clinics after receiving a diagnosis of obesity and attend on a regular basis – usually every three to six months – to receive support losing weight. The consultant and a group of 18 patients from the two clinics agreed to have their consultations video-recorded over a period of nine months, leading to a collection of 39 recorded consultations and over 25 hours of data. These consultations were transcribed and analysed using insights from conversation analysis (CA) (Sacks, Schegloff and Jefferson, 1974) a qualitative approach that investigates the actions performed by ‘turns’ at talk and the accomplishment

of interaction through the unfolding of sequences of talk.

The prevalence of obesity in the UK has been presented by governments and healthcare organisations as a significant health issue for over ten years (National Audit Office, 2001), with current estimates predicting that 60% of men, 50% of women and 25% of children in Britain will be obese by 2050 (Foresight, 2007). A variety of policy initiatives have been launched (most recently see, Department of Health, 2011) to promote healthy eating and exercise behaviours across the population and to provide weight loss care for those who fall into the category of obese. Healthcare policy has also prescribed and codified the interactional practices expected of practitioners treating obese patients. These prescriptions are in particular set out in a 2006 document produced by the National Institute for Health and Clinical Excellence (NICE) on ‘... the prevention, identification, assessment and management of overweight and obesity in adults and children’. It states that ‘[g]ood communication ... is essential’ to the encounter (p. 7) and advises that ‘health professionals should follow the usual principles of person-centred care’ (p. 7). It also advises practitioners to tailor advice-giving to individual patient needs, use jargon free language and negotiate with patients over treatment. One particular prescription within the NICE document initiated a piece of analysis in this project. Section 1.2.4.7 states that: ‘To encourage the patient through the difficult process of changing established behaviour, healthcare professionals should praise successes – however small – at every opportunity.’

Verbal praise-giving, in the form of compliments, is a highly interesting and accessible topic for the detailed study of naturally occurring interactions. This simple recommendation therefore became a starting point for analysis.

Once this topic had been chosen, the data were reviewed to build a collection of all instances of compliment-giving by the consultant in the recorded consultations. These compliments were then transcribed and analysed with particular attention given to: when in the consultation they occurred; how they were designed and delivered by the consultant; and how they were responded to by patients. The results are summarised below. They indicate that in this institutional context praise is both difficult to deliver and receive. This appears to be a consequence of the consultant’s limited capacity to witness patient successes and the ways in which patients attend to a normative constraint against self-praise whilst also working to position themselves as ‘good’ patients in the obesity healthcare context. These results enhance empirical and conceptual understanding of healthcare interactions and reveal that the apparently simple and straightforwardly positive recommendation to give praise does not capture the complexities of actual interactional practice. Selected transcripts are discussed to illustrate the typical findings across the dataset. These transcripts use the Jefferson (1984) notation system common to CA, marking interactional phenomena such as word stress via underlining, ‘.’ to display rising intonation and numbers in brackets to indicate the length of silences in seconds. Where relevant, video-still images (blurred to

protect the anonymity of participants) are included to illustrate the physical positions of the consultant and patient. The arrow links the video-still to the relevant moment in the transcript.

Results

Delivering praise

The action of verbal praise-giving has been analysed from a variety of perspectives as compliments.

Fragment A

1. Cons: That's fantastic

Fragment B

1. Cons: Well done

Both turns in Fragments A and B treat the result of the patient's weighing examination as positive, however only the turn in Fragment B credits the patient directly for this. 'Well done' functions as a stock congratulatory phrase short for 'Well done by you', whereas 'That's fantastic' comments only on the weighing result itself and does not specify who is responsible for it. In this context a 'fantastic' result may be understood as due to the patient's own actions, or alternatively the successful consequence of an anti-obesity drug or bariatric surgery etc. So the turn in Fragment A, and similar turns found across the data, can be seen as more 'diluted' compliments than the turn in Fragment B, which credits the patient directly. Over 200 instances of Fragment A type turns were observed

Compliments are 'supportive interchanges' that perform the action of an assessment (Pomerantz, 1978) which additionally attributes credit to another, usually the recipient, for something which can be understood as 'good' by both speaker and recipient (Holmes, 1988). In the obesity clinics turns that might be seen as compliments attribute credit to the patient either directly or indirectly. Consider Fragments A and B below. Both are delivered after the patient has been weighed.

in the data but only 36 instances of Fragment B type turns were found. The likely reasons for this difference are discussed below. As the 'stronger' form of compliment, the Fragment B type is focused on in the remainder of the analysis.

Compliments directly crediting the patient are delivered by the consultant at various stages in the consultation and typically refer positively to 1) the patient's appearance 2) reported patient activities 3) the result of the weighing examination and 4) the patient's overall progress. In the transcripts below each compliment is highlighted in bold. In Fragment 1 the consultant directly credits the patient for a (medically) positive appearance shortly after greeting her at the start of the consultation.

Fragment 1 The patient has entered the room and sat down at the start of the consultation.



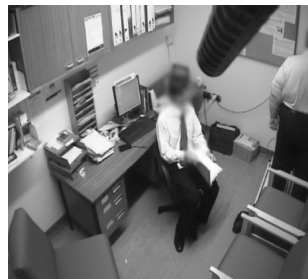
1. Cons: ↑
 Y' looking we:ll

In Fragments 2 and 3 the consultant uses 'well done' to directly credit the patient for reported activities about going to the gym (Fragment 2) and the result of a weighing examination (Fragment 3).

Fragment 2 Whilst reporting her activities in between appointments the patient is telling the doctor about her visits to the gym. This transcript begins in line 18 as earlier exchanges are shown later in the paper.

18. Pat: You know, I really do enjoy going, I'm
19. ↑no-not scared to go in places like that
20. any mo:re,
21. (0.6)
22. Pat: That's[that's another tick for me bo:x
23. Cons: [(° °)
24. Pat: you kno:w
25. Cons: **We:ll done**

Fragment 3 The patient is standing on the scales and both he and the consultant are looking at its digital read out.



1. ↑
Cons: **Well done**

Fragments 4 and 5 occur during the treatment discussion phase of the consultation. The consultant directly credits the patient's progress (Fragment 4) and ability (Fragment 5) as part of a longer discussion. In each case the consultant marks this credit as his own opinion – 'I think' and 'which strikes me that'.

Fragment 4

1. Cons: ↑Okay, so: I don't think I've got
2. anything else to change un I: cos I think
3. you are doing so well,

Fragment 5 The patient has just commented on her experiences of dieting as a 'rollercoaster' involving periods of doing well and periods of being unsuccessful. The consultant carries on the metaphor in his turn.

1. Cons: But actually wuh-one of the things
2. which strikes me is thut .hh when
3. you:'ve when you've actually fallen
4. o:ff (.) **you cun actually get straight**
5. **back on agai:n.**

These fragments illustrate the patterns found across the data. Compliments directly crediting the patient are delivered by the consultant across the various stages of the consultation but are comparatively rare and refer to a limited range of topics. This seems to reflect the consultant's limited opportunities to witness patient success within the consultation. The status of obesity as a 'lifestyle' condition means that much of the encounter is taken up with the patient reporting back his or her behaviours away from the consultation, to be assessed but not directly witnessed by the consultant. A typical consultation begins with the patient delivering a verbal update on his or her activities between appointments. These activities are open to discussion but cannot be witnessed directly. In fact the consultant can only directly witness and assess the patient's appearance, the results of the examination phase (weighing and sometimes other tests such as body fat measurements) that

occurs after the discussion of patient progress, plus the patient's overall progress over time – typically as part of the treatment advice and discussion phase towards the end of the encounter. Consequently it may be difficult for the consultant to directly credit the patient without 'evidence'. It is also possible that a positive report from a patient at the start of the encounter – about exercise behaviours for instance – may be contradicted by a later weighing result. If the consultant has praised the patient's reported behaviour, and this report is then undermined this might require the earlier praise to be withdrawn or recalibrated. This could create tensions in the interaction, perhaps embarrassing the patient and even threatening the consultant's expertise. As such, the prevalence of Fragment A type turns in these data may be because this kind of indirect assessment provides an easier means to comment on matters that have not been witnessed. By comparison direct

credits carry more risk within the interaction. Furthermore the frequent inclusion of opinion markers in the directly crediting compliments, such as in Fragments 4 and 5, may display the consultant's limited, subjective access to assess the patient's progress and leave room for this opinion to be modified if necessary.

Analysis reveals that the action of delivering verbal praise is an interactionally complex one in the obesity clinic context. We can develop this analysis further by considering how patients respond to compliments from the consultant.

Responding to praise – the requirement to avoid self-praise

In interactional terms, responding to compliments is always difficult. As an assessment a compliment sets up another assessment as a relevant action in response. An agreeing response is 'preferred' as an easier action to perform since disagreement can cause difficulties within the interaction (Pomerantz, 1984). For instance, we can see that a comment from one speaker about the weather being 'very cold today' projects a response from the second speaker that also assesses the quality of the weather, with an agreement over its coldness being interactionally easier to produce. However in the case of compliments, competing with this preference for agreement is a social sanction against self-praise. If we appear to strongly agree with praise delivered to us, we risk appearing immodest and this is something that others may disapprove of and even comment negatively on. In

her seminal analysis of compliments in mundane interactions Pomerantz (1978) observes that recipients of compliments produce responses which fall between agreement and disagreement and which display modesty rather than self-praise. This includes simple appreciations of the compliment given – 'thank you' etc – or the return of a compliment to the compliment giver. Other responses shift the praise onto another object or give a kind of weak disagreement by downgrading the quality of the praise. For instance, the recipient of a compliment about appearance might shift the praise given from the attractiveness of a new hairstyle to the skilfulness of the hairdresser who produced it or downgrade the praise to refer to the hairstyle as 'alright' in response to 'great'. Other analysts (e.g. Knapp, Hopper and Bell, 1984; Jones, 1990) have also observed that in some instances recipients may produce no response at all to a compliment, either by not talking or producing talk relating to a separate topic.

The interactional difficulties associated with responding to compliments are highly relevant to the ways in which patients in these data respond to verbal praise-giving from the consultant. Patients produce a variety of response types, which avoid or minimise self-praise. They also appear to draw on and reflect the specifics of the obesity healthcare setting. In eight instances in the collection of 36, patients produce no response to the praise given. This can be seen in Fragment 6.

Fragment 6 at the start of the consultation, both the patient and consultant are standing near the entrance to the room.

1. Cons: How are you then?
2. Pat: I'm very well, thank you.
3. Cons: mm::hmm.

↓



4. (0.3)
5. Cons: You look it.
6. (0.4)

↓



7. Cons: Hang on. Sorry. Have a seat

Occurring at the start of the consultation, the exchange in lines 1-2 functions as a greetings sequence. In response to the patient's 'I'm very well, thank you.' the consultant produces 'mm::hmm.' with a rising then falling intonation that suggests a positive, even admiring stance. As he says it, he looks directly at the patient for an extended period, appearing to make a visual assessment of him. After a pause the consultant adds 'You look it.' The 'it' is hearable as referring to the patient's 'very well' so the consultant transforms the patient's own reference

to directly credit him with having a positive (healthy) appearance in a way that – in this environment - suggests his treatment progress is visible. During the pause in line 6 the patient starts to move towards a chair. The consultant is standing in his way and his turn in line 7 is spoken as he moves aside. The patient does not produce any response to the doctor's compliment. His action of moving to a chair is consistent with the opening of the consultation. The doctor does not pursue a response from the patient or comment on the absence of any response so does not

appear to treat this silence as in any way problematic.

Appreciations of the compliment were made in only three instances.

This can be seen in Fragment 7. The patient's response is highlighted in bold.

Fragment 7 continues Fragment 4

1. Cons: ↑Okay, so: I don't think I've got
2. anything else to change un I: cos I think
3. you are doing so well,
4. Pat: **Okay** ^{oo}>**thank you**<^{oo}

As we have seen, the consultant praises the patient's overall treatment progress in line 3. In response the patient first acknowledges this, 'Okay', then gives the appreciation, 'thank you'. He does not say any more at this point so his turn does not extend the topic of him being creditworthy in any way. As such the patient avoids appearing to self-praise beyond the acceptance of the consultant's compliment. The patient produces the appreciation very quietly and quickly – as indicated by the small circles and angular brackets in the transcript. This delivery suggests the patient experiences a degree of difficulty producing the response – a recurrent theme throughout the data.

No responses and appreciations are typical compliment responses observed across a variety of settings. There are no instances in these data of a patient returning a compliment to the consultant – which would of course appear rather strange in this asymmetric, institutional context.

There are also no straightforward instances of the patient shifting the object of the praise or downgrading it. Investigation of the remaining cases in the data reveals that patients in fact routinely agree with the praise given or shift the referent whilst implicitly accepting the praise. This contrasts with compliment responses in other settings and can be connected to certain normative dynamics operating in the obesity healthcare setting. This is discussed next.

Responding to praise – normative dynamics in the obesity healthcare setting

The most common compliment response in the data (seventeen cases) is an agreement. In the fragment below, the patient produces an agreement in a minimal form, 'mmm', after a 0.6 second silence.

Fragment 8 continues Fragment 5

1. Cons: But actually wuh-one of the things
2. which strikes me is thut .hh when
3. you:'ve when you've actually fallen
4. o:ff (.) you cun actually get straight
5. back on agai:n.
6. (0.6)
7. Pat: **mmm.**

In contrast to existing studies of compliments, explicit agreements are common in these data. Agreements can be heard as a kind of self-praise and place patients at risk of censure for being immodest. So why might they be so common here? We can begin to understand this by considering

the broader interactional context in which the compliment is delivered. In Fragment 9 below the patient says ‘Yeh’ in response to the consultant’s ‘We’ll done’. The fragment illustrates more of the interaction first seen in Fragment 2.

Fragment 9 extends Fragment 2

1. Pat: Trying to do all the ‘ard we:rk which I
2. still am, you know the gym,
- [15 lines omitted – the patient talks about what she does at the gym]
18. Pat: You know, I really do enjoy going, I’m
19. ↑no-not scared to go in places like that
20. any mo:re,
21. (0.6)
22. Pat: That’s[that’s another tick for me ho:x
23. Cons: [(° °)
24. Pat: you kno:w
25. Cons: We’ll done
26. (0.5)
27. Pat: **Yeh**

The patient is giving an update on her treatment activities between appointments. She does not simply report what she has been doing but builds her talk to display her personal effort and commitment to losing weight. She reports that she is still making an effort to work hard (line 1) is going to the gym (line 2), is enjoying it (line 18) has overcome a fear of places like that (line 19) and that this is ‘another’, one of several, successes – ticks for her box – that she has accomplished (line 22). This is typical of the ways patients across the data perform ‘moral work’ to position themselves as ‘good patients’ in the obesity clinic (Webb, 2009b). Patients consistently build descriptions of their treatment

behaviours, progress etc to demonstrate that they are making an effort to lose weight, that they are committed to the process, are knowledgeable about their condition and in particular that they are personally responsible for any successes. This moral work in fact resonates very strongly with the messages governments and healthcare systems put out regarding obesity as a lifestyle condition requiring personal responsibility and commitment to change as well as broader societal understandings of fatness as undesirable (see methods and data section, above). In the interactional context, patients’ self-reports of success and appropriate behaviours establish an environment in which some kind of praise from

the practitioner is highly relevant (Maynard, 2003). Here the patient's tag question 'you know' explicitly solicits a response from the consultant, who responds with an interactionally appropriate compliment, 'Well done' in line 25.

This compliment sets up the familiar tension between a preference for agreement and a requirement to avoid self-praise. However the patient's prior moral work presents an additional complexity. If she produces a typical modest compliment response – perhaps shifting the praise onto a different object, by saying her gym is really good, or by downgrading the quality of the praise – the patient also undermines her previous report emphasising her effort and commitment. At best she would appear insincere in her modesty and at worst she would appear inconsistent, perhaps unreliable in her account of her treatment behaviours. This could threaten her status as a 'good' patient. By contrast an agreement ensures that the patient remains consistent with her prior description of successful effort. This agreement does self-praise, but by not upgrading it or expanding the topic it does so minimally.

In the specific context of the obesity clinic modest responses

to compliments can risk patients undermining their own displays of success. By contrast agreements provide a means for patients to appear consistent and reliable in their displays of being 'good'. In Fragment 8 the patient's response occurs in a similar interactional context to Fragment 9. The patient has spent time describing her commitment to a diet regime and her continued success despite it feeling like a rollercoaster. Any modest response to the consultant's subsequent compliment risks undermining this display of personal success. However an agreement maintains a consistent status, and once again its minimal design limits the degree of self-praise produced.

The final response type found in the data (eight cases) attends to the same kinds of normative concerns and also differs from typical compliment responses found in other analyses. Patients reference the topic of the praise in a way that does not disagree with or downgrade it and does not shift the praise to another person or object. In Fragment 10 the patient in fact upgrades 'well' to 'very well'. She also changes the reference of the consultant's turn from 'looking' to 'feeling'.

Fragment 10 continues Fragment 1

1. Doc: Y' looking well

2. Pat: E::r **feeling very well**

In Fragment 11 the patient responds to the consultant's compliment regarding his weighing result by stating that he thought his weight would have gone

up. Despite the modesty displayed, the response implicitly accepts the positive result and the praise.

Fragment 11 continues Fragment 3

1. Doc: Well done
2. Pat: .hhh
3. (1.5)
4. Pat: **To be honest I thought it ud of gone up**

Once again consideration of the wider interactional context suggests that these unusual compliment responses relate to the ways in which patients position themselves as ‘good’ patients in the obesity consultation. Fragment 10 occurs at the start of a consultation in which the patient is about to report significant success managing her diet with a new anti-obesity drug. If she treats the consultant’s ‘Y’ looking we:ll’ in a typically modest way her subsequent report of this success may appear inconsistent or unreliable. Her actual response is consistent with her upcoming report and the change from ‘looking’ to ‘feeling’ – in addition to marking a difference between what the consultant is able to assess and what she is able to assess – allows her to implicitly agree with the compliment without appearing to self-praise. It also displays that she has been reflecting on her health status – another instance of moral work. The patient in Fragment 11 has spent a considerable amount of the consultation leading up to the weighing examination emphasising his efforts to lose weight and to ease the heart problems he is experiencing. His weight loss supports this account of his effort. If he modestly downgrades the consultant’s compliment he risks undermining the way he has positioned himself as a good patient. Instead his response displays modesty without downgrading the compliment or suggesting that he is not responsible for his own success. It also conveys

that he had previously formed his own assessment of his weight status, something a ‘good’ patient could be expected to do.

With these two kinds of responses patients perform sophisticated interactional work. They deal not only with the delicacy of responding to compliments but also with potential conflicts arising from the normative dynamics operating in the obesity clinic setting. Their responses keep self-praise to a minimum but nevertheless maintain, even extend, their position as ‘good’ patients making an effort and personally responsible for success. As observed previously, there are considerable delays before patients produce these responses – 0.6 seconds (Fragment 8) 0.5 seconds (Fragment 9) 1.5 seconds (Fragment 11 – only partially taken up with the patient stepping off the scales) plus the elongated ‘E::r’ in Fragment 10. In interactional terms a silence of half a second or more before a response often signals some kind of ‘trouble’ (Sacks, Schegloff and Jefferson, 1974); in these data, in addition to slowing down the interaction, these delays suggest that patients are experiencing difficulty producing their responses.

This analysis has investigated compliments and compliment responses in naturally occurring specialist obesity consultations. Using a conversation analytic approach the results indicate that the actions of giving and responding to compliments are

interactionally complex in this setting and closely associated with certain institutional and normative dynamics of obesity healthcare. As is discussed further below these novel findings enhance healthcare communication analysis and offer highly practical implications for the conduct of the consultation. This analysis thereby demonstrates the analytic and practical value of drawing on healthcare guidance prescriptions of interaction as a starting point for the detailed analysis of naturally occurring practitioner-patient interactions.

Discussion

This paper demonstrates the empirical, conceptual and practical value that can be derived from drawing on prescriptions of 'good' communication practices as a starting point for the analysis of healthcare interaction. Increased opportunities for detailed analyses of naturally occurring face-to-face communication – brought about by the use of recording technologies in data collection – coincide with a growing codification of communication in healthcare training and guidance. Combining these two contemporary developments provides an opportunity for further research that enhances understanding at the interpersonal level of healthcare communication analysis in novel and fruitful ways. This has been illustrated through a report of a piece of analysis that was initiated by a single guidance prescription.

In the UK, healthcare policy on obesity advises that: 'To encourage the patient through the difficult process of changing established behaviour,

healthcare professionals should praise successes – however small – at every opportunity'. Data collected in two specialist clinics were drawn on to investigate how verbal praise-giving in the form of compliments was delivered and responded to in consultations with obese patients. Using a conversation analytic approach the results indicate that compliments directly, rather than indirectly, crediting the patient are relatively rare and that this connects to the limited opportunities the clinic consultant has to witness patient successes. The consultant is able to directly witness and assess the patient's appearance, examination results and progress over time but much of the consultation is taken up with the patient reporting back on behaviours between appointments. As these behaviours cannot be witnessed it may be difficult to credit the patient for them without 'evidence'. It is also possible that information reported by the patient may be subsequently undermined by other information in the consultation. Hence more diluted compliments giving indirect credit are more common in the data than directly crediting ones. Furthermore, directly crediting compliments marked as opinion are also common. In their responses to directly crediting compliments patients orient to a requirement to avoid or minimise self-praise, for instance by providing no response to the compliment or a simple acceptance without extending the topic. These kinds of response have also been observed in other analyses of compliments; however whereas existing analyses observe that compliment responses typically fall between agreement and disagreement,

in these data minimal but explicit agreements are the most common form of patient response. In addition rather than producing responses that shift or downgrade the praise given, patients produce different kinds of references that implicitly accept the praise. These responses are very closely connected to the dynamics of the obesity healthcare setting: patients frequently perform moral work to display and highlight their commitment to the process of losing weight and their personal responsibility for successes. In the interactional environment created by this moral work typical modest compliment responses risk the patient appearing insincere or even undermining his or her own display of success. By contrast a minimal agreement enables the patient to appear consistent whilst keeping self-praise to a minimum. References to the topic of the praise that do not disagree with or downgrade it similarly enable the patient to maintain a consistent status whilst minimising self-praise and even extending the moral work performed. In these responses patients perform highly sophisticated interactional work that attends not only to the delicacy of responding to compliments but also with potential conflicts arising from the dynamics operating in the obesity healthcare setting. The frequent instances of silence between compliment and response plus the sometimes quiet and rushed delivery of responses suggests that patients experience difficulty producing these sophisticated replies.

By drawing on a specific piece of healthcare guidance regarding face-to-face communication as its starting point, this investigation

of compliments in obesity clinics makes both analytic and practical contributions. In analytic terms the findings enhance understanding of health and communication in a number of ways. They advance empirical understanding of how specialist care for obesity unfolds: this is particularly significant as the direct observation of obesity healthcare – in contrast to recollections of this care gathered through interviews and surveys – remains an underdeveloped area of investigation in the social sciences. This direct and detailed observation approach illustrates the kinds of interactions that occur within this setting and also conceptualise how these interactions might be shaped by – and in turn shape – broader healthcare and cultural understandings of obesity. For instance the relative infrequency of compliments directly crediting the patient appears connected to the consultant's limited access to assess treatment behaviours which predominantly occur away from the medical gaze (Foucault, 1973). The work patients perform to maintain their status as committed and personally responsible for successes even whilst minimising self-praise resonates with the emphasis healthcare systems place on individual responsibility for obesity and societal understandings of fatness as undesirable. These findings also advance empirical and conceptual awareness of healthcare interactions more generally, highlighting the ways in which normative concerns around patienthood frequently become visible and the ways in which the orientation to certain institutional and normative dynamics can result in different kinds of talk than observed in other -

particularly mundane, non-institutional – environments. Finally, the ways in which the consultant and patient alternately display their limited access to assess progress and their ability, even expertise, to make a personal assessment of progress appears highly relevant to the treatment of various long-term, chronic conditions and our understanding of the practitioner-patient relationship in these kinds of healthcare setting.

The practical contributions of the analysis centre on its illustration of the complexities involved in praise-giving in the obesity healthcare context. The guidance that initiated this analysis presents praise-giving as straightforwardly positive and beneficial to the patient. These findings problematise the assumptions made in this, following Peräkylä and Vehviläinen (2003), stock of interactional knowledge and offer a more nuanced understanding of these interactional actions. Without suggesting that praising is not a worthwhile activity or that patients do not benefit from it, the results of the analysis illustrate that it is nevertheless inherently complex in this setting. In the first instance it can be difficult for practitioners to identify an opportunity to praise success, given their limited access to witness it directly and the possibility that patient reports of success may be contradicted by other information in the consultation. Furthermore giving praise places pressure on the patient to navigate a complex interactional environment and form a response that avoids self-praise but maintains an appropriate normative position. Although patients frequently display considerable

interactional dexterity in producing responses that successfully navigate this environment, the frequency of delays in their responses indicates they experience some difficulty doing so. With this in mind, attempts to follow the guidance and praise success ‘at every opportunity’ would place a great deal of pressure on the practitioner to discern when a relevant occasion arises and would risk tensions arising if any praise subsequently appears wrongly given or is retracted. In addition praising at every opportunity would also maximise pressure on the patient to produce an appropriate response to each instance of praise-giving and may also have the effect of slowing down the consultation.

The increasing focus in studies of face-to-face communication on detailed, real time analyses of naturally occurring healthcare interactions coincides with the increasing codification of communication in healthcare guidance and training so that drawing on this guidance as a topic or starting point for analysis enables the generation of findings that are novel and insightful in empirical, conceptual and practical terms. This represents a fruitful approach for further research that can enhance understanding at the interpersonal level of healthcare communication analysis, in particular by illuminating the intricate relationship between interaction and healthcare delivery. In the case of obesity healthcare, the interactional action of praise-giving can be further scrutinised to determine, for instance, whether there are some compliment designs that patients experience less difficulty responding to or phases of the consultation in which compliment

delivery and response incurs fewer interactional complexities. In addition other prescriptions on communication in the NICE document cited earlier in the paper offer starting points for analysis, such as the requirement for negotiation over treatment and tailoring advice-giving to individual

patient needs. The results of these kinds of analysis – and others drawing on prescriptions in different healthcare fields – would advance analytic understanding whilst offering practical implications and thereby produce an optimum contribution to healthcare communication analysis.

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