

Surgeons' affiliative responses to patients' troubles-telling in outpatient consultations

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Declaration

This thesis contains no material which has been accepted for the award of any other degree of diploma in any University, and, to the best of my knowledge, this thesis contains no material previously published except where due reference is made. I give permission for the digital version of this thesis to be made available on the web, via the University of Adelaide's digital thesis repository, the Library Search and through web search engines, unless permission has been granted by the School to restrict access for a period of time.

Phoebe Hender

1 October 2019

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Abstract

Empathy is recognized as an important way for medical professionals to demonstrate understanding of patients' experiences and as such, is arguably a key aspect of patient satisfaction in the provision of healthcare. Existing research has examined affiliation as displays of understanding, compassion or agreement by physicians, enabling the integration of empathy in primary care and complementary health settings. Surgeon-patient interactions have received comparatively less analytic attention, prompting the current research on empathic communication in this context. The current study demonstrates the ways in which surgeons routinely responded to patients' affective expressions of a trouble or problem in diagnostic consultations, through affiliative and non-affiliative displays. Conversation analysis was used to examine the integration or absence of this form of empathy in 75 surgeon-patient consultations, recorded in a metropolitan public hospital. The findings of this research suggest that patterns of surgeon-patient interaction are similar to those observed in general practice and homeopathy, with minimal and extended sequences identified, containing both affiliative and non-affiliative responses to patients' troubles-telling. The nature and consequences of these responses are explored with consideration to the broader institutional aims of the consultation. Implications of these observations for patient-interaction are discussed in relation to professional training of empathic communication.

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Surgeons' affiliative responses to patients' troubles-telling in outpatient consultations

CHAPTER ONE: INTRODUCTION

1.1 Background

Successful healthcare provision has been found to be dependent on the quality of interaction between health professionals and their patients (Drew, Chatwin & Collins, 2001). To facilitate therapeutic outcomes, strong communication skills in active listening, empathy and support are required (Frankel, 1995). In particular, affiliative displays of empathy are argued to be an important way for doctors to communicate their understanding of patients' subjective experience (Ford, Hepburn & Parry, 2019). As such, physicians' empathic communication skills have been associated with patient satisfaction and compliance with treatment regimens (Kim, Kaplowitz & Johnston, 2004). The absence of interpersonal skill has emerged in studies of medical error and malpractice suits, in which the decision to litigate was the result of a perceived lack of caring or understanding in the delivery of health care (Beckman, Markakis, Suchman & Frankel, 1994). This recognition of empathic communication as a feature of the medical encounter has driven the ongoing development of interpersonal skills training, with a view to improving the quality of physician-patient interaction (Kurtz, Silverman & Draper, 2005). The current study will further demonstrate the importance of empathy in the context of surgical outpatient consultations. For the purposes of this research, empathy will be conceptualised within the institutional context of medical practice, in line with Ford et al's definition: "statements in which the doctor shows his or her understanding of the patient's emotional experience" (2019, p. 25).

The ability of health professionals to demonstrate empathy in the medical encounter has been previously examined in response to patients' descriptions of a trouble or problem (Ruusuvuori, 2005; Ruusuvuori, 2007). The concept of troubles talk is considered a socially organised construct that occurs in conversation (Jefferson, Drew, Heritage, Lerner &

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Pomerantz, 2015). “Troubles-telling” sequences are commonly encountered as a feature of institutional talk in the existing literature (Jefferson & Lee, 1992, p. 400). In ordinary conversation, descriptions of a trouble or problem usually elicit affiliative responses from the recipient (Ruusuvuori, 2005). In the context of a medical consultation however, this is further complicated by the fact that a patient’s trouble also signifies a problem to be solved (Jefferson & Lee, 1992). Health professionals are required to prioritise patients’ clinical problems, often at the expense of other problems that may arise during the encounter (Ruusuvuori, 2007). The nature of medical interaction is such that a troubles-telling sequence demands a primary focus on the health professional providing a solution to the trouble, via a task-driven response (Ruusuvuori, 2005). However, the integration of empathy in response to a troubles-telling can serve to make the clinically driven tasks of a medical encounter, affiliative in nature (Ford et al., 2019). Observed differences in managing troubles-telling accounts as a feature of the medical encounter, imply that physician-patient relations are often bound by the constraints of their institutional context (Drew & Heritage, 1992). The current study will explore affiliative patterns of interaction that occur in the context of surgical outpatient consultations, in response to patients’ troubles-telling. These findings will contribute to a growing body of research on interpersonal skills training amongst surgeons, to evidence the ways in which patients’ affective displays are managed within this setting.

1.2 Literature review

1.2.1 The function of empathy in healthcare provision

The integration of empathy in the physician-patient relationship has been shown to positively influence the desired outcomes of healthcare with respect to patient satisfaction, adherence to treatment advice and the prevention of malpractice suits (Frankel, 1995). Empathy has been further examined in terms of an affiliative response to opportunities that arise during the medical encounter when patients express emotion (Suchman et al., 1997). In

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a thematic analysis of primary care visits conducted in urban medical clinics, researchers explored these affective aspects of patient interaction (Suchman et al., 1997). It was found that when patients were given an opportunity to verbally express an affect rather than an emotional cue, surgeons were more likely to respond with an explicit acknowledgement of this display (Suchman et al., 1997). Other researchers have drawn on these findings to examine the affiliative display of empathy as a response to a troubles-telling, across a range of healthcare contexts. These included settings of pre-operative assessment by nurse practitioners (Benwell & Rhys, 2018), peer-support helplines for community mental health concerns (Pudlinski, 2005), general practice and homeopathic consultations (Ruusuvuori, 2007). These studies offer a comparison of the ways in which the expression of a trouble is both received and responded to by a range of health professionals in a variety of institutional contexts.

A conversation analytic study on medical interaction in preoperative assessment demonstrated the use of a troubles-telling sequence, as a means by which for nurses to negotiate the medical relevance of patient concerns regarding their upcoming surgery (Benwell & Rhys, 2018). In orienting with patient disclosures of a trouble, the nurses created an interactional space for patients to express these concerns regarding their procedure, whilst exhibiting empathy (Benwell & Rhys, 2018). Research has further identified different methods used in the expression of empathy on a peer-support helpline using conversation analysis (Pudlinski, 2005). Affiliative responses in this context commonly occurred within a troubles-telling sequence, differing in both their placement and affective expression (Pudlinski, 2005). Empathy was integrated at various intervals of a troubles-telling and such responses differed in their depth of understanding towards the caller's presented trouble (Pudlinski, 2005). Ruusuvuori (2007) provided further examination of health professionals' response types, to patients' affective expression of a trouble or problem in general practice

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and homeopathic consultations conducted in Finland. Using conversation analysis, this research classified response types as minimal and extended sequences that were either affiliative or non-affiliative in nature (Ruusuvuori, 2007). In the context of both general practice and homeopathic consultation, a minimally affiliative response was found to merely imply an understanding of the trouble, whilst an extended affiliative response served to exhibit this understanding (Ruusuvuori, 2007).

Recent literature on the physician-patient relationship has examined the multi-dimensional function of empathy in the provision of healthcare (Ford et al., 2019). A study of palliative care in the United Kingdom, established the integration of empathy in the medical encounter as a way for doctors to demonstrate their understanding of patients' subjective experience (Ford et al., 2019). In this context, empathy was found to bridge an interactional gap between the doctor's expertise-driven, and the patient's experiential, perspectives (Ford et al., 2019). Ruusuvuori (2007) further showed how empathy was integrated into the institutional task of resolving a patient's problem, in both general practice and homeopathic consultations. In attending to patients' troubles-telling with an affiliative response, health professionals made possible the closure of this sequence by removing the opportunity for patients to continue with their problem description (Ruusuvuori, 2007). As such, the integration of empathy facilitated a return to the medically driven aims of the interaction (Ruusuvuori, 2007). In a deviant case observed in homeopathy alone, this return to the medical agenda was driven by the patient following an extended affiliative sequence (Ruusuvuori, 2007).

Based on the framework proposed by Ruusuvuori (2007), the current study will explore the ways in which surgeons respond to patients' troubles-telling or problem presentations in the outpatient environment. Following this existing body of literature, the function of empathy as an affiliative response to troubles talk will be considered within this comparative context.

1.2.2 The absence of empathy in medical interaction

Medical interactions in which patients exhibit strong negative emotions have been described as some of the “most difficult encounters” reported by physicians (Platt & Keller (1994 p. 222). Possessing the interpersonal skills of empathic communication are crucial in managing such difficult aspects of the medical encounter (Platt & Keller, 1994). Consequently, the absence of empathy in medical interaction has remained a key focus of the literature. In a thematic analysis of 20 consultations undertaken in a United States hospital, researchers demonstrated how surgeons and oncologists failed to show empathy in their interactions with lung cancer patients’, when presented with their concerns or displays of emotion (Morse et al., 2008). Empathic responsesⁱ to patients’ affective displays were identified in only 10% of the 384 opportunities presented (Morse et al., 2008). This pattern of missed empathic opportunities was further evidenced in a primary care setting of general medicine in the United States (Suchman et al., 1997). Using thematic analysis, it was observed that physicians consistently failed to affiliate with empathic opportunities that were defined as “a direct and explicit description of an emotion by a patient” (Suchman et al., 1997, p. 679). Researchers found that such opportunities were frequently left unacknowledged by the physician and in some cases, were actively terminated via a change of topic (Suchman et al., 1997). This often facilitated a return to the medical task at hand, such as the exploration of symptoms (Suchman et al., 1997). Ruusuvuori (2007) established further evidence of health professionals’ non-affiliative responses, in the context of patients’ troubles-telling. Aligned with the above research, extended non-affiliative responses in this context consisted of statements that maintained or shifted the focus of discussion to the health-related nature of the interaction (Ruusuvuori, 2007).

ⁱ These were coded into themes that included patients’ statements about impact of lung cancer, patients’ statements about lung cancer diagnosis or treatment and patients’ statements about health system issues affecting their care (Morse et al., 2008).

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The current study will build upon these findings to examine the non-affiliative responses of surgeons in the outpatient environment. Following thematic analyses of missed empathic opportunities in the medical encounter, this research will examine the circumstances of interaction in which surgeons fail to affiliate with a troubles-telling sequence. Consistent with Ruusuvuori (2007), this research will apply conversation analysis to determine the systematic structural organisation behind surgeons' responses (Heritage & Maynard, 2006).

1.2.3 Conversation analysis applied in a medical context

Distinguishable from other qualitative methods that rely on anecdote, intuition or prior theorising, the theory of conversation analysis (hereafter CA) has been put forward as a uniquely systematic approach to the organisation of interaction (Heritage & Maynard, 2006). In the medical encounter, CA has enabled the analysis of doctor-patient interaction at the levels of structural organisation, sequential organisation and turn design (Heritage & Maynard, 2006). In the context of general practice and homeopathy, CA has been used to identify patients' affective expressions of emotion and the integration of empathy as a feature of the consultation (Ruusuvuori, 2005; Ruusuvuori, 2007). Institutional practices of surgeon-patient interaction in an outpatient environment have been similarly examined using a CA approach (White et al., 2013). Using this method, researchers were able to determine the ways in which surgical consultations were structurally distinct from their primary care counterparts (White et al., 2013). Building upon this existing body of research, the current study will adopt CA to explore similar patterns of interaction, with a comparative focus on surgeons' responses to patients' troubles-telling.

1.2.4 Professional skills training in empathic communication

The notion of whether clinical empathy is a teachable skill has been contested in the literature (Pehrson et al., 2016). Platter and Keller (1994) proposed that empathy can be taught "just as skiing, tennis or surgery can be taught" (p. 226). In line with this theory, Hojat

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(2007) argued that deficits in empathy “can be improved by therapeutic approaches” (Hojat, 2007, p. 181). A review of studies concerned with the effectiveness of interpersonal skills training provided further empirical support for this notion (Stepien & Baernstein, 2006). Improvements in the behavioural empathy of undergraduate medical students have been associated with a range of interventions (Stepien & Baernstein, 2006). Furthermore, studies have found that empathy amongst medical students and residents experiences a decline over the course of their education, in the absence of ongoing interpersonal skills training (Hojat, 2007). A similar pattern has been reported for qualified doctors, beyond their medical training (Stratta, Riding & Baker, 2016). These findings imply an ongoing need for interpersonal skills training in empathic communication, both as a feature of medical education and throughout the medical career, in the form of professional development.

Existing formal communication skills training for general surgical residents is highly variable in methods of teaching and assessment (Nakagawa, Fischkoff, Berlin, Arnell & Blinderman, 2019). Many interventions promote institutionally driven tasks of communication such as informed consent or shared decision making, rather than skills for managing emotion and empathic communication (Nakagawa et al., 2019). In light of this research, the present study aims to generate findings that might inform the development of these programs by making use of evidence from actual outpatient interactions.

1.3 Setting for the current study

The current study describes the ways in which surgeons respond to patients’ affective expressions of a trouble or problem in surgical outpatient consultations. Literature in medical communication suggests that surgeon-patient interaction has a unique structure, distinct from its primary care counterparts (White et al., 2013). It is in the nature of surgical consultations, that more severe medical problems requiring surgical intervention, are involved. As such, patients may experience heightened emotion regarding their medical condition or concern

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that surgical treatment may involve some risk to life. Consequently, the current setting poses a greater likelihood of patients' affective expression, thus producing more opportunities for empathic response on the part of the physician.

The analytic focus of this research is concerned with a specific type of interaction common to medical consultations: patients' troubles talk. For the purposes of this research, patients' sequences of troubles talk in this setting will be referred to as a "troubles-telling", defined by Jefferson and Lee (1992, p. 400). Patients' initial descriptions of the reason for their visit that elicit a response from the surgeon, will also be identified (Ruusuvuori, 2007). For the purposes of this research, these sequences will be labelled a "problem presentation" (Heritage & Clayman, 2010, p. 104).

This study will apply CA to examine how surgeons use empathy in responding to patients' troubles-telling in the outpatient environment. Surgical consultations receive comparatively less investigation than their primary care counterparts, limiting the existing literature on empathic communication to a sub-section of possible medical interactions (White et al., 2013). Therefore, further analysis of the surgeon-patient interaction is important, to ensure that assumptions of best practice fit a variety of functionally different healthcare settings.

CHAPTER TWO: METHOD

2.1 Setting

The video recordings analysed in this study were collected as part of a broader investigation, for the research project: Surgical Coaching in the Outpatient Environment (SCOPE). The dataset consisted of 75 video recordings of surgical outpatient consultations that took place in a South Australian metropolitan public hospital. A number of these consultations were made on a referral basis, whereby patients had been referred to the surgeon by their general practitioner or a specialist, for further medical investigation or

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proposed surgery. In some cases, the consultation served as a follow-up appointment to review the outcome of treatment or test/scan results, while others functioned as a post-operative appointment to determine the extent of recovery following a recent surgery. Each consultation began with an introduction initiated by the surgeon. In some cases, the surgeons reacquainted themselves with patients they had met previously. These initial pleasantries were typically followed by the surgeon establishing the patient's reason for the visit and taking a brief medical history.

The physical arrangement of the consultation rooms was standard. Surgeons sat at a desk on which there was a computer used for examining letters of referral, displaying diagnostic tests, and also for making notes. One surgeon made hand-written notes when taking his patients' medical history. Physical examinations of patients during these consultations occurred either in an adjacent room or behind a curtain.

2.2 Participants

There were 75 video recordings taken of standard outpatient surgical consultations with consenting surgeons and patients. Eleven surgeons, including ten males one female, participated in the study. These participants were recruited from the surgical specialties of Upper Gastrointestinal, Colorectal, Breast and Endocrine and Urology, within the same South Australian metropolitan public hospital. All participants in the corpus of video recordings were aged 18 years or older. The age range of participating patients was between 18 and 90 years of age, these included 39 males and 36 females. In 17 of the recorded consultations, the patient was accompanied by either relatives or a caregiver.

2.3 Procedure

This study was approved by the Central Adelaide Local Health Network (CALHN) Human Research Ethics Committee (see Appendix A). A formal notification of human research ethics approval was also submitted to the University of Adelaide and accepted by

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the Human Research Ethics Secretariat and Legal and Risk Office (see Appendix B). Written consent was obtained from participants prior to their involvement in this study, as part of the Surgical Coaching in the Outpatient Environment (SCOPE) research project that was conducted in the hospital.

For the purposes of the present study, the recordings were closely examined via repeated observation to identify all sequences in which a patient described a trouble or problem. These instances amounted to 36 examples in total. Surgeons' responses to instances of a troubles-telling or problem presentation were then analysed using conversation analysis, as applied to institutional interaction in a medical setting (Drew & Heritage, 1992).

2.3.1 Transcription

Sequences of surgeon-patient interaction were initially transcribed verbatim, in order to identify patterns of troubles-telling sequences and problem presentations within the dataset. A detailed annotation of selected excerpts was then carried out using the Jefferson Transcription System for Conversation Analytic Research, to reflect the sequential features of talk-in-interaction (Jefferson, 2004). Unlike other methods of transcription, the Jefferson system provided a level of analysis that enabled an accurate interpretation of speech; including changes in tone, pitch, volume, pauses and overlap. This method of transcription captured the talk as it was heard, serving to emulate the actual interaction as closely as possible (Hepburn & Bolden, 2017). This was achieved through the detailed annotation of speech, using symbols of notation outlined in the Jefferson Transcription System (see Appendix C) (Jefferson, 2004).ⁱⁱ

ⁱⁱ Potter & Hepburn (2012) note that Jefferson transcription is a slow process, involving a time ratio of 1 hour of recorded material to 20 hours of annotated transcription. As such, sequences of interaction are transcribed with a targeted focus on an analytically identified theme or question.

CHAPTER THREE: ANALYSIS

The following analysis applied the framework proposed by Ruusuvaori (2007) for the analysis of Finnish health professionals' affiliative responses to patients' affective expressions of a trouble or problem. Sequences of interaction were identified in which patients described a trouble, defined as a "troubles-telling" by Jefferson and Lee (1992, p. 400) and surgeons responded in some way. Following Ruusuvaori (2007), troubles-telling sequences systematically included reference to a negative assessment of their condition or an experience of personal hardship. Patients' descriptions of their initial reason for the visit were similarly identified in the dataset, defined as a "problem presentation" by Heritage and Clayman (2010, p. 104). These were considered the "the primary opportunity for patients to describe their problem" (Heritage & Clayman, 2010 p. 104). Based on the framework proposed by Ruusuvaori (2007), the current study examined surgical outpatient consultations with reference to two types of surgeon response: 'minimal' and 'extended'. These response types were further categorised as involving either affiliative or non-affiliative displays.

Following Ruusuvaori's classification, *minimal affiliative responses* were characterised as involving "a compassionate expression, or a short verbal response" (2007, p. 600). In this expression, the surgeons "implicate that they understand the patient's troublesome situation... but they do not exhibit their understanding, for instance by giving details of equivalent circumstances" (Ruusuvaori, 2007, p. 600). By contrast, *minimal non-affiliative responses* were characterised as involving a "neutral acknowledgement" to patients' troubles-telling that was delivered with falling intonationⁱⁱⁱ (Ruusuvaori, 2007, p. 600). *Extended affiliative responses* were defined broadly as varying from "explicit claims of affiliation... to elaborate detailing of circumstances parallel to those the patient has described" (Ruusuvaori,

ⁱⁱⁱ Following Ruusuvaori (2007), similar responses that were delivered with a rising or level intonation were considered 'continuers', i.e., responses that facilitated a "continuation of the patient's troubles-telling" rather than as signalling affiliation.

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2007, p. 600). In displaying or claiming to have knowledge of a similar experience to a patient's troubles-telling, these extended responses enabled the surgeon to exhibit their understanding (Ruusuvuori, 2007). *Extended non-affiliative responses* were further classified as "various kinds of phrasal or clausal response that focus on solving the health-related problem rather than on showing compassion" (Ruusuvuori, 2007, p. 600). In attempting to use the four-way categorisation proposed by Ruusuvuori (2007) to describe Finnish health professional-patient interactions, the observed surgeon-patient interactions in aligned with previous observations noted in general practice and homeopathy. However, the findings of the current study did not fit this framework categorically and in some instances, proposed new patterns of interaction that were the consequence of a given response.

The aim of the following analysis is to describe how surgeons routinely responded to a troubles-telling by patients. These respective sequences will be referenced using the overarching term of "troubles-telling" hereafter. The focus of this study is on surgeons' turns that implied or exhibited understanding of patients' troubles-telling. Interactions in which the surgeons failed to produce an affiliative turn were also considered in this analysis, along with the consequences of this type of response for the ensuing interaction. These observations support the general framework of responses proposed by Ruusuvuori (2007) but add some further patterns in the comparative context of surgical outpatient consultations. The analysis, below, begins with a single observed instance of a surgeon's minimally affiliative response to a patient's troubles-telling.

3.1 Minimal responses to patients' troubles-telling

3.1.1 Minimally affiliative

A *minimally affiliative response* was characterised as involving a short compassionate expression from the surgeon to a patient's troubles-telling. The current dataset contained only one instance of minimal affiliation as shown Excerpt 1, compared with the proposed pattern

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identified in the Finnish data of general practice and homeopathy (Ruusuvuori, 2007).

Aligned with the findings of Ruusuvuori (2007), the surgeon acknowledged the patient's affective expression with a brief empathic response but treated this as a secondary concern to the ongoing discussion of the medical problem at hand.

Just prior to the excerpt below, the surgeon has been explaining the benefits of surgery for a prolapsed bowel to a patient who is hesitant to undergo the procedure. As the excerpt begins, the surgeon is describing how the procedure will resolve the patient's current health issue of bladder leakage (lines 1-4).

Excerpt 1

[Consult: 15: 75]

S= Surgeon, P= Patient

1 S: I- I don't think you can really fully address
2 your (.4) leakage issues until we stop your
3 prolapsing >and the prolapsing has a lot< to do::
4 with your leakage (.8) ↑alright?
5 P: Isn't that aw:ful? [Getting old]
6 S: [It is- it is aw↓ful
7 P: Getting old is (.) terrible
8 S: I'll get you to sign just here sweet
9 and I'll get ya back on my ** list
10 (.5)
11 so are you clear about the operation?
12 P: I'm cle:ar about the operation

In line 4 the surgeon seeks the patient's agreement with the proposed form of treatment using a tag-question-formulated statement: "alright?". At this point, the patient orients to her problem (leakage of urine) using an assessment that is similarly framed to seek agreement from the surgeon: "Isn't that awful?", together with an account for her condition: "Getting old" at line 5. In his response, the surgeon can be seen to affiliate in overlapping agreement, repeating words that the patient herself has used: "It is- It is awful", at line 6. This brief display of affiliation implies the surgeon's understanding of the patient's trouble. The patient continues on the topic of her trouble with a further assessment: "Getting old is terrible" at line 7, to which the surgeon does not affiliate any further. At line 8, he shifts the focus of

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discussion back to the institutional goal of the consultation by requesting the patient's signed consent for the proposed surgical treatment. The patient does not take another turn at talk at this point, and the topic of her troubles-telling is effectively closed. At this point, the surgeon puts forward a closed-question that implies an attempt to conclude the interaction in a "final-concern sequence", which obligates a yes or no type answer (Robinson, 2001, p. 647).

Typically designed with a bias, these questions prefer answers that "decline to topicalize additional concerns and acquiesce to a shift into closing" (Robinson, 2001, p. 647). In this sequence, the surgeon's minimally affiliative response precedes a closure of the patient's troubles-telling sequence, closely followed by a return to the medically driven aims of the consultation.

This example of minimal affiliation with a patient's troubles-telling in a short verbal response, was implicative of understanding the patient's troublesome experience. This sequence was interpreted as an example of the pattern described by Ruusuvuori (2007), whereby minimal affiliative responses facilitate the closure of a troubles-telling, in that they are typically followed by a return to the medical aims of the interaction. However, given the solitary example of this type of response in the current dataset, a consistent pattern of interaction was not observed in the same way that Ruusuvuori (2007) proposed.

3.1.2 Minimally non-affiliative

Minimally non-affiliative responses were characterised following Ruusuvuori (2007), as involving neutral acknowledgements that were delivered with falling intonation, signalling the surgeons' receipt of a troubles-telling. Distinct from an affiliative response, these sequences involved surgeons orienting to patients' affective expressions without evidence of implied understanding or compassion. The following excerpts provide examples of surgeons' minimal non-affiliative responses to patients' troubles-telling.

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Excerpt 2 demonstrates a surgeon's minimal non-affiliative response to a troubles-telling, in the context of discussion around the patient's medical condition. Prior to this sequence, the patient has been providing a brief medical history concerning his hernia and associated weight gain. The surgeon asks the patient to provide more detail, to which the patient responds with a troubles-telling of the circumstances surrounding his condition, beginning at line 4.

Excerpt 2

[Consult: 16: 75]

S= Surgeon, P= Patient

1 S: te:ll me a bit more about the weight ga:in (.)
2 over what period of time have you put on that
3 amount of weight?
4 P: uhm (.5) just over a period of fourteen mo:nths=
5 S: =ri:[ght]
6 P: [uhm it's been through depression, (.)
7 stress and anxiety.=I had a split from my part:ner=
9 S: =ri:ght
10 P: uh of uhm eleven ye:ars
11 S: ye:ah
12 P: and uhm it go- come down to the point where I've (.)
13 tried to commit suicide as we:ll
14 S: ri::ght
15 P: so uhm [so it's been pretty stressful
16 S: [yeah]
17 over the last- last fourteen (.) >months or so.< (.)
18 I now have um (.) uhm a uhm:: a:: counsellor
19 who I::'m see:ing
20 S: that's good
21 P: =[Olivia ((0.2))
22 S: [yep yep]
23 P: at St- at Stanley Pa:rk
24 S: yeah [yep (.) ok:ay]
25 P: [I- I've done 11 sessions with her now
26 S: ri:ght
27 P: and uhm I've found it >very very< helpful
28 S: good
29 P: and uh I (.) hhh depending on my (.) in:juries
30 and that I can (.) start back at work
31 on the [twenty-se[cond of November (.)
32 S: [Ye::ah] [okay<
33 and what sort of work do you do?

The patient's troubles-telling account offers a description of psychological distress and relationship breakdown, culminating in a suicide attempt. The surgeon orients to the patient's

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troubles-telling at various points throughout, with neutral acknowledgements of “Right” and “Yeah” (lines 9, 11, 14, 16). These utterances are delivered with falling intonation, and as such, are identified as instances of receipt/acknowledgement of the information, rather than displays of understanding or compassion, following Ruusuvuori (2007). At line 20, after the patient’s report that he is now seeing a counsellor to manage his distress, the surgeon provides an assessment: “That’s good”, which lacks the empathic markers of an affiliative response. The repeated acknowledgements of “yep yep” and “yeah, yep, okay” at lines 22 and 24, delivered in overlap with the patient’s attempts to provide further detail about his counsellor, are implicative of closing the patient’s sequence of troubles talk. Aligned with research in CA, this suggests that a closing in the surgical outpatient environment can be facilitated through an exchange of “possible pre-closings” (Heritage & Maynard, 2006, p. 384). Tokens of “yep” and “okay” function as pre-closings, that signal that the speaker is attempting to close a sequence of talk (Wong & Waring, 2010). Here, the surgeon does indeed close the patient’s troubles-telling sequence shortly thereafter (line 32), returning to the medical agenda of completing case notes by asking his next question: “and what sort of work do you do?” (line 33). In the medical context, this *and*-prefaced question signals the bureaucratic nature of the interaction, invoking the surgeon’s institutional aims (Heritage & Sorjonen, 1994). This question enables the surgeon to proceed to the next task with minimal acknowledgement of the patient’s prior response, moving forward in their discussion within the trajectory of the consultation (Heritage & Sorjonen, 1994).

The following sequences provide two examples of interaction that emerged as a consequence of surgeons’ minimally non-affiliative responses. This was observed where patients’ affective expressions were not met with an empathic response, causing them to take the next turn in addressing the surgeon, with a line of questioning that extended the sequence.

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These questions drew upon the surgeons' expertise to gather further information from their medical perspective, as illustrated in the two excerpts below.

In Excerpt 3, involving a patient with a mass on her liver, the surgeon has completed the patient's medical history and asks if he can examine her stomach, before they discuss her treatment options. In an overlapping sequence at line 8, the patient cuts off the surgeon's talk to initiate a troubles-telling regarding her medical condition.

Excerpt 3

[Consult: 54: 75]

S= Surgeon, P= Patient

- 1 P: oh you will explain what's gonna [happen (.) ne:xt?
2 S: [yeah and [then I explain
3 P: [yep]
4 S: what's gonna [happen, or what the possi:bilities
5 P: [happen next?]
6 S: which can go (.8) to um happen next {.5} uhm::
7 and (.5)[yes]
8 P: [I'm really nervou-
9 I'm sort of nervous because I'm [worried it is a can:cer
10 S: [yeah< yeah< yeah<
11 P: um[hhh=
12 S: =[ye:ah]
13 P: would [you (.) to take it ↑out
14 S: [but li-
15 P: [would you- would you suggest<?
16 S: [uhm]
17 we just need to know a bit m:ore about it
18 just to uhm:: (.9) probably (.4) to uhm (.)
19 reduce a bit the nervousness of you,
20 there are a lot of uhm (1.1) tu:mours.=Tumour means
21 only um anything that gr:ows which is not u::hm
22 the same (.) which the tissue beneath, means (.) um
23 a lot of benign tumours on the li:ver. (.7) so the
24 ma- ma:jority of lesions we see are benign:, (.5)
25 so are just there.=a lot [of patients-
26 P: [what is benign?=
27 S: =benign means um good (.) it's- it's not malign
28 means tha' it's not a ca:ncer so it's just there
29 and it doesn't affect you in your li:fe and will be there
30 until the end of your life and doesn't
31 cause you any [problems
32 P: [you don't know how scared I fwas doctor
33 no jo:ke

At line 9, the patient's troubles-telling sequence yields a "self-initiated self-repair", as defined by Hutchby and Wooffitt (1998, p. 61). In this correction, the patient reduces her

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affective expression of “I’m really nervou-” to “I’m sort of nervous”, which appears to downgrade the troubles-telling. She concludes this sequence to explain that she is “worried it is a cancer”, referring to the mass on her liver. The surgeon does not explicitly affiliate with the patient’s trouble here but produces a series of repeated “yeah” responses in overlap with her statement of worry, that offer a neutral acknowledgement of her concern, beginning at line 10. In an overlapping turn that coincides with the patient’s attempts to continue her trouble-telling, the surgeon concludes his acknowledgement in a final “yeah”, spoken with falling intonation (line 12). Here, the patient’s turn is not met with an empathic response that orients to the affective component of the talk. What unfolds in the ensuing interaction is further questioning on the part of the patient that involves an attempt to gather information from the surgeon on her condition. The surgeon provides a response, beginning at line 16, that now indicates that he has registered the patient’s earlier troubles-telling. He orients to the emotion expressed by the patient in her previous turn using similar language, in the somewhat minimised term: “nervousness”. His framing involves a receipt and acknowledgement of her affective experience, but does not serve, in Ruusuvuori’s (2007) sense, to affiliate with the patient’s trouble as such. However, given the medically driven nature of the patient’s trouble here, the surgeon’s response appears to provide the patient with adequate reassurance, despite lacking this affiliative quality. This is evidenced with an overlapping sequence at the closure of the surgeon’s response, in which the patient affirms her relief with a tone of breathiness that implies suppressed laughter (Jefferson, 2004): “you don’t know how scared I was doctor” at line 32.

Excerpt 4 below, exhibits a further instance of a minimally non-affiliative response in the dataset. In this example, the patient has been referred to the surgeon to discuss a recent diagnosis of Idiopathic Thrombocytopenic Purpura (ITP). The following discussion is centred around the surgeon’s proposed treatment of surgery to remove her spleen.

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Excerpt 4

[Consult: 46: 75]

S= Surgeon, P= Patient

- 1 P: °ahh:: um (.8) what else do I wanna know?° (.)
2 <I'm not worried about the actual process of surgery
3 °as I say I've sort of got the i:dea° (.6)
4 it's just the uh what's that going to mean (1.5)
5 for my life on- going on .hhh I just don't wanna be
6 sickly and< (.8)
7 S: no:=
8 P: =mm (2.3) and what about if you tra:vel you just
9 carry antibiotics with [you?
10 S: [yep (.9) yep (1.2)
11 ((surgeon turns to face patient)) ↓°yeah°
12 P: °mm° <so I've heard va:rying things like (.5)
13 antibiotics for the rest of your life, (.5)
14 antibiotics for two years:: (.7) like, (.6)
15 wha:t's the deal (.5) with that?
16 S: uh::m (.8) most of the patients we have will be immunised
17 and won't need uhm (.7) uh will- will have antibiotics
18 or carry antibiotics with them .hhh uh some people will
19 need it (.) °you know° as a low dose (.) uhh all the
20 time .hhh uhh (.8) we'd probably get the haematologist
21 to give some uhh ad:vice on ↑that because< (1.3)
22 P: ye:ah

In this interaction, the patient states her concern in a troubles-telling sequence about the consequences of this surgery for her quality of life: “I just don’t wanna be sickly” (lines 5 and 6). The surgeon’s receipt of this information with the neutral acknowledgement: “No”, delivered with falling intonation, implies his agreement with the patient’s assessment of her circumstances but does not exhibit explicit affiliation with her troubles-telling account. The patient’s utterance of “mm” immediately following the surgeon’s response without a pause, holds the turn in this sequence, allowing her to proceed with a further line of questioning (lines 8 & 9). In doing so, the patient shifts the interaction back to the medical agenda in order to clarify the logistics of travel with her condition. This consequence of further questioning following a lack of affiliative response to patients’ troubles-telling is consistent with the interaction observed in Excerpt 3. Unlike the previous sequence of this nature described in Excerpt 3, the surgeon’s initial response to the patient’s question does not directly address her trouble or offer reassurance in this case, merely providing confirmation

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to her question in a series of utterances. The surgeon does eventually acknowledge the difficulty of the patient's decision towards the end of the consultation but maintains that a splenectomy is her best option under these circumstances.

Consistent with Ruusuvaori's findings (2007), these instances of minimally non-affiliative responses observed in the current study of surgeon-patient interaction were characterised by neutral acknowledgements such as "yeah", "right" or "no", delivered with falling intonation. What was noted in the surgeon-patient interactions examined here was that a non-affiliative response sometimes prompted further medically related questioning from patients (illustrated in Excerpts 3 and 4). As such, a shift back to the medical agenda of the consultation was largely driven by the patient, rather than the surgeon. This adds to the finding of Ruusuvaori (2007), that patients may instigate such a shift in deviant cases of interaction. However, the circumstances under which this transpired in the current dataset are distinct from those identified in homeopathy. These observations build upon existing research to offer new insights on the integration of minimal non-affiliative displays in surgeon-patient interaction.

3.2 Extended responses to patients' troubles-telling

3.2.1 Extended affiliative

Extended affiliative displays from surgeons were also identified in response to patients' affective expressions of a trouble. These interactions differed from previously described instances of minimal affiliation, in that the response moved beyond a brief empathic statement of implied understanding to allow an extended sequence of responses on the part of surgeons. The extended sequences of affiliation identified in the excerpts below were consistent with Ruusuvaori's descriptions (2007). However, the contexts in which these sequences arose in the current dataset were not categorically aligned with her findings. Ruusuvaori (2007) described two closely related local contexts in which an extended affiliative response was integrated into general practice and homeopathic consultations. The

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first enabled the closure of a troubles-telling sequence through extended displays of affiliation on the part of the health professional, in which case the patient's trouble was managed as separate to the medical aims of the consultation (Ruusuvuori, 2007). The other served to complete the institutional aims of the consultation itself, whereby the patient's affect was managed as a feature of the medical task (Ruusuvuori, 2007). In the current study, extended affiliative responses were identified in the former context exclusively. Consistent with previous findings, patients' affective expressions were managed as an independent focus from the medical aims of the consultation, evidenced in the following excerpts.

Excerpt 5 depicts an extended affiliative response to a troubles-telling in which the patient has received a referral for endometriosis. Just prior to the excerpt, the surgeon has taken the patient's medical history and begins to explain details of the surgical procedure she is scheduled for. During the surgeon's description of risks associated with the surgery, the patient begins to cry (line 21). At this point, the patient's affective expression of emotion instigates an extended sequence of troubles-telling.

Excerpt 5

[Consult: 12: 75]

S= Surgeon, P= Patient

1 S: .hhh so if you can ima:gine, you've got
2 a big wad of stuff he:re
3 P: °yep°=
4 S: =um I'll be guided by De:an [<Doctor Findlay about the::
5 P: [yep]
6 S: aims of sur[gery o:kay?
7 P: [yep]
8 S: so obviously we need to take
9 >your ovaries your fallopian tube out<
10 P: (h)yep
11 S: um but it'll- <he'll also guide me on- on how much disease
12 he would like me to help him to remove, (.) [o:kay?
13 P: [okay]
14 S: so in the pro:cess (.) there's always a risk that you can
15 get an injury to bowel
16 P: mm:hm
17 S: uhm and that can be a- just a minor little tear=
18 P: =yep
19 S: sometimes it can be a bit more, it can be a b:ig tear (.7)

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20 so my job will be to prevent th:at, (.7) to re:pair it=
21 P: =yep so(h)rry (h)I'm getting em(h)otional
22 ((patient crying)) .hhh hhheh
23 S: yeah >nah nah< that's o:kay, that's fine (.7)
24 umm (.7) it is a big thing, it's been takin' over your life
25 you lost your job for it or you're not wor[king
26 P: [(h)yep
27 S: you know. .hhh has he given you a date?
28 P: .hhh no he wanted to wait 'til (h)today
29 S: okay (.) no worries we- I generally will help him
30 on a Monday mor:ning
31 P: (h)↑yep
32 S: uhm so we'll- we'll try to tee up a time (.7)
33 for [ya (.) okay:?]
34 P: [yeah (.) 'cause it uh hhh okay wo:rk (.)
35 obviously I had to give up,
36 S: yep=
37 P: =I had to move back to me mu:ms
38 S: yes
39 P: .hhh but um (.) the medication that I'm on
40 and obviously you get side effects from- sorry=
41 S: =yeah yeah and also with the hormone changes too
42 my good[ness
43 P: ['cause I'm not sleeping at [night]
44 S: [would drive ya ↑nuts (.)
45 um=
46 P: =if I knew:: (1.1) I never knew endo can come back (1.1)
47 I on[ly found that out this year
48 S: [how old are you no:w?]
49 P: forty-n(h)ine
50 S: =oh it should be burning out by now
51 P: hmm
52 S: um I'm a bit surprised actually but< why don't you have
53 a lie do:wn a::nd let me have a feel of your tummy

The surgeon suspends the medical agenda (of surgery description) at line 23, to affiliate with the patient's troubles-telling sequence and provide an assessment of her affective expression: "yeah nah nah that's okay, that's fine". He follows this to further exhibit an understanding of the troubles-telling, using phrases from the patient's own description of her condition provided earlier in the consultation, affirming that "it is a big thing, it's been takin' over your life" at line 24. In this affiliative response, the surgeon appears to register the previous details of their interaction, inferring that the patient's expression of emotion is justified. The patient acknowledges in an overlap, that the surgeon's formulation of her trouble is correct (line 26), at which point the surgeon shifts the topic back to the medical

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agenda to query whether the gynaecologist has given her a date for the operation itself.

Following an initial affiliative display, this shift suggests an attempt to draw the troubles-telling sequence to a close. This is evidenced by the surgeon's use of topic-shift markers (Ainsworth-Vaughn, 1992) "okay" and "so" that preface and end his next turns: "okay (.) no worries ..." (line 29), and "uhm so we'll- we'll try to tee up a time for ya (.) okay?" (lines 32 and 33). However, at this point (line 34), the patient takes turn and pursues further affiliation from the surgeon by extending the sequence to list a series of troubles she has experienced in recent months. The surgeon briefly acknowledges each trouble with utterances of "yep" and "yes" that indicate further attempts to close the troubles talk. However, when the patient describes a trouble related to her medication (line 39), the surgeon again claims affiliation with a response cry: "my goodness". He exhibits an understanding of the side-effects she has experienced from medication, in the assessment: "would drive ya nuts", delivered with a steep rise in pitch. The patient takes the next turn here and continues her extended troubles-telling, to which the surgeon responds with a question that establishes closure of the troubles-telling account with a shift back to the institutional aims of the consultation (lines 52 and 53). In line with Ruusuvuori (2007), these findings suggest that an extended affiliative response in the context of surgeon-patient interaction facilitates the closure of a troubles-telling sequence and subsequent return to the medical agenda.

Excerpt 6 depicts a further instance of extended affiliation observed at a later stage of the consultation described above. The surgeon has just completed a physical examination of the patient in the adjacent room before returning to conclude the consultation. In this sequence, the patient displays emotion as she initiates an extended troubles-telling to describe her experience in greater detail, beginning at line 12.

Excerpt 6

[Consult: 12: 75]

S= Surgeon, P= Patient

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1 P: I've been waiting to see you like you
 2 wouldn't be:l(h)ieve ((patient laughs))
 3 S: well I- I'll text him (.5) [and just let him know
 4 P: [°thank you°]
 5 S: that I've caught up with ya and we can start looking
 6 at a date (.) okay?
 7 (.8)
 8 P: .hhh I'm over crying< it's jus-
 9 (h)I'm really sorry g(h)uys
 10 S: ↑no no you're ɛRI:ght don't apo:logise, (.)
 11 don't apologise
 12 P: it's just living with p(h)ain every da:y
 13 S: yes [°I ↓know°]
 14 P: [when you've been used to working since
 15 you were fifteen, you know?
 16 (.9)
 17 S: °no I understand°=
 18 P: =and ye:ah moving back to your mums at forty-ni:ne
 19 hhh (.) so (.)
 20 S: °<I must admit that I still°> try to get to my mums
 21 for dinner every ()=
 22 P: =ye::ah I know I know .hhh
 23 S: she cooks so good< I hope your mum cooks well
 24 P: ye::ah she does but ye::ah she ca-
 25 I don't think she can handle what I'm going thro:ugh
 26 S: oh okay °>yeah yeah<°
 27 P: umm (.5) yeah to know her daughters not we:ll
 28 and she's gotta have an operation, 'cause we lost dad=
 29 =it'd be coming up next week to three years with dad
 30 so (.) .hhh <I- I only moved back in March:: <April
 31 this year so (.) I just [couldn't do it anymore]<
 32 S: [I- I actually think that
 33 she'd love to have you around=
 34 P: =oh yeah she does [love it]
 35 S: [I think all mums love to have
 36 their kids around

The patient invites a response from the surgeon with the tag question: “you know?” at line 15. The surgeon takes the next turn to respond accordingly in a statement of agreement: “no I understand” delivered with a quiet tone of voice, implying that he does not wish to interfere with the patient’s ongoing troubles talk. The patient continues a description of her troublesome experience with reference to her change in lifestyle, moving back home with her mum (line 18). In an affiliative response, the surgeon exhibits his understanding of the patient’s situation, with a description of his own equivalent experience of going to his mum’s

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house for dinner. Consistent with Ruusuvuori (2007), the surgeon temporarily abandons the medical agenda in this instance, to affiliate with the patient's trouble in an extended response. The surgeon invites further commentary from the patient on this topic, with the remark: "I hope your mum cooks well" at line 23 with which the patient takes turn, to offer a more detailed description of her trouble. In an overlapping sequence with the patient's preceding troubles-telling account, the surgeon concludes his extended display of affiliation with the assessment: "I actually think she'd love to have you around" (lines 32 & 33). As proposed by Ruusuvuori (2007) this extended affiliative sequence facilitates the closure of ongoing troubles talk, evidenced by the patient's immediate agreement: "oh yeah she does love it" (line 34). This sequence also brings about a subsequent return to the medical agenda. Following this excerpt, the surgeon passes the patient a consent form and her handbag, while getting to his feet to show her out, thus signifying the end of the consultation.

Excerpt 7 provides a further case of an extended affiliative response to patients' troubles-telling, in a separate consultation. In this example, the patient is attending a follow-up appointment to determine the outcome of radiotherapy for a diagnosis of bowel cancer. The surgeon asks the patient a series of questions to determine the extent of her recovery and the patient responds with a description of her troubles with mobility (line 2).

Excerpt 7

[Consult: 15: 75]

S= Surgeon, P= Patient, C= Carer

```
1 S:    al::right ((helps patient out of wheelchair))
2       do you use a wheelchair ↑often?
3 C:    y(h)ep
4 S:    what's tha:t ↓for?
5 P:    yeah< I've lost (.) [I'm losing
6 C:    'cause [of her back=
7 S:    =what's going on with your ba:ck?
8 P:    arthr(h)itis (.) I'm losing< (.)
9 S:    oh no you poor thing=
10 P:   =I'm losing my legs .hhh
11 S:   um have you seen anyone about this at all?
12     (.7)
13 C:   uhm we actu::- well- well we have in the past
```

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14 and they- they put us through to <what's the-
15 what's the (1.7) massaging (.) [bloke
16 S: [uhm °okay°
17 C: um >what are they [called aga:in?<
18 P: [()]
19 °oh no°
20 S: uh are you gonna be stable on your feet?
21 =Is it just tough getting up?
22 C: she can- she can walk around
23 P: [yeah I can walk around yeah<
24 S: [okay]
25 alright, well we'll get this out of the way (.)
26 come- come through in he:re
27 (2.2) ((leads patient through to examination room))
28 C: ()
29 S: are you gonna be- it's pretty tough
30 getting in and out of bed isn't it?
31 P: ye:ah my back

The excerpt begins with the surgeon assisting the patient out of her wheelchair, as she explains in a troubles-telling, that arthritis is causing her to lose full use of her legs. The surgeon can be seen to affiliate with the patient's experience at line 9: "oh no you poor thing". This initial display of affiliation implies the surgeon's understanding of the patient's trouble. In the sequence that follows, he extends the response in a way that also exhibits his understanding with a series of questions. Displaying knowledge from his medical perspective, the surgeon provides insight as to how the patient must physically feel: "it's pretty tough getting in and out of bed isn't it?" (lines 29 and 30). Consistent with findings of Ruusuvuori (2007), this response facilitates a closure of the patient's troubles-telling, followed by a subsequent shift back to the medical task of completing the patient's physical examination.

These extended sequences of affiliation in surgeon-patient interaction were consistent with patterns observed in general practice and homeopathic consultations by Ruusuvuori (2007). In their affiliative displays, the surgeons claimed or displayed knowledge that exhibited an ability to understand the patient's experience of a trouble. These responses also made possible the closure of troubles-telling and a return to the medical aims of the interaction.

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3.2.2 *Extended non-affiliative*

Extended non-affiliative sequences in the dataset were characterised by surgeons' phrasal or clausal responses that maintained the focus of interaction on the institutional aims of the medical agenda. In such cases, a pattern was observed in which surgeons oriented to the patient's troubles-telling by way of addressing the medical issue at hand. This was evidenced by surgeons' use of task-driven questioning in response to patients' affective expression of a trouble. These questions from surgeons were observed to occur in the place of an empathic acknowledgement, and involved the surgeon obtaining further medical history on the nature of the patients' presenting trouble or problem.

Excerpt 8 illustrates an example of an extended response from the surgeon in which he briefly receipts the patient's troubles-telling, while continuing to drive the medical agenda of the consultation. In this sequence, the surgeon informs the patient that he seems to be recovering well from his operation considering his age and the previous state of his health. At this point, the patient initiates a troubles-telling to disconfirm the surgeons' assessment that he is "doing well" (line 4) and describe his experience living with a colostomy bag, beginning at line 5.

Excerpt 8

[Consult: 6: 75]

S= Surgeon, P= Patient

- 1 S: the main thing wa:sto get you over all this (.8)
2 and [uh get you back on your fe:et which you are=
3 P: [yeah well-]
4 S: =you are doing we:ll
5 P: yeah (.6) >oh I'm doing al:right >y'know< only thing
6 is- is that I do have a problem with this (.8) >y'know<
7 is uh (.8) well< () so an' <it's- it's
8 hard to get ↑used to
9 S: yes
10 P: you know it's ↑very hard (.6) y'know
11 and I'm sayin' I'm lookin' at it in the mirror
12 try'na (.8) clean meself up and all that sort of thing,
13 'cause you know I change it twice a day, (.6)
14 in the morning and in the evening ()
15 S: is that very liquid-y stuff com↑ing?

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16 P: hey?
17 S: is it very watery coming from ↑that?
18 P: not watery uh- uh- just soft very soft
19 °yeah (.) yeah°
20 S: and how many bags full are you emptying? (1.5)
21 you would say it's a bag full a da:y or-

The emotive nature of the patient's extended troubles-telling in this interaction is noted in the rising pitch of his description at lines 8 and 10, which serves to emphasise the difficulty of this experience. The surgeon initially responds part way through this sequence, with a neutral acknowledgement: "yes", that receipts the patient's trouble at line 9. Once the patient concludes his troubles-telling account, the surgeon responds with a series of task-oriented questions about the type of waste product in the colostomy bag. His response serves to acknowledge the patient's trouble and extends the sequence in a medical problem-solving manner. However, his immediate focus on the medical aims of the interaction neither implies nor exhibits an understanding of the patient's experience.

Excerpt 9 highlights a further instance of an extended response given without affiliation to a patient's problem presentation. In this example, the surgeon initiates the consultation to ask how the patient is going, prompting an extended problem presentation from the patient.

Excerpt 9

[Consult: 10: 75]

S= Surgeon, P= Patient

1 S: um (.) >how you going<?
2 P: um yeah not very go::od um it's been really hard,
3 'cause I'm in pain every da:y (.8)
4 and umm=
5 S: =in the tummy?
6 P: ((points to stomach)) he:re (.8) and< (.6) and
7 down there >and here and here< (.9) and I wake up
8 every night and it- hurting< and even now sitting
9 wiv my pants pressing on it, it's hurting
10 down he:re [I can't<
11 S: [how long have you had the pain for now?
12 P: ohh hhh umm (.) I ca:n't remember (.9) I know<
13 S: would you say ye:ars?
14 P: uh::m
15 (1.1)
16 S: have you had the pain on and off for ye:ars?
17 P: yeah

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Here, the patient begins her problem description using extreme-case formulations (underlined) at lines 2-3: "... it's been really hard, 'cause I'm in pain every day". In his response, the surgeon attends to the medical aims of the consultation to ask the location of her pain, rather than affiliating with her experience. His question is met with a verbal and gestural description of the locations of her pain, accompanied by further troubles-telling that involves another extreme-case formulation: "every night", at line 8. The surgeon again does not offer affiliation at this point but maintains focus on the medical task at hand by asking a series of further task-related questions that seek to determine the duration of her experience with pain.

The observed instances of extended non-affiliative responses in the dataset were consistent with Ruusuvaori's (2007) classification for general practice and homeopathy, including clausal or phrasal sequences that oriented to the medically driven aspects of a patient's trouble or problem. The context in which extended non-affiliative responses were observed was in the initial stages of the consultation, at which point the surgeons were involved in a process of medical history taking. This implies that the preliminary stages of patient interaction in this setting, were less conducive to affiliative responding on the part of surgeons, due to the task-driven nature of this initial encounter.

In the current context, it was expected that patients might be more emotionally expressive in their troubles-telling, due to the relative severity of their medical conditions compared with those found in general practice and homeopathy. While the interactional circumstances involved in surgical consultations typically differ markedly from these settings, a comparable pattern of affiliative and non-affiliative responding to patients' affective expressions was observed.

CHAPTER FOUR: DISCUSSION

4.1 Overview

The aim of the current study was to demonstrate the ways in which surgeons respond to patients' troubles-telling in an outpatient environment. Reinforcing previous research findings, surgeons integrated displays of empathy as a feature of their interaction with patients, to manage the institutional demands of the consultation (Ruusuvuori, 2007; Ford et al., 2019). Surgeons' responses were analysed within the framework proposed by Ruusuvuori (2007) on the basis of observations in general practice and homeopathic consultations. These included minimal and extended sequences of interaction, involving either affiliative or non-affiliative displays. This structural pattern of interaction was similarly observed in the current context, with some variation noted in the frequency of response types and the development of new findings in a comparative setting of surgical outpatient consultations. The minimal and extended affiliative displays of surgeons enabled this integration of empathy as a feature of the consultation, in responding to patients' troubles talk. Consistent with the findings of Pudlinski (2005), these observed sequences differed in the depth of understanding they conveyed to patients' troubles-telling. In line with this existing research, an emotive reaction such as use of compassionate language found in a minimally affiliative response, implied a minimal sense of understanding. Comparatively, formulating the gist of the trouble in an extended affiliative sequence, exhibited a stronger sense of understanding the trouble and its significance for the patient.

While the findings of this study are consistent with the general framework of interaction proposed by Ruusuvuori (2007), some patterns were observed more consistently than others in the context of surgical outpatient consultations. Only one definitive case of minimal affiliation was identified in the current dataset, that fitted the classification used by Ruusuvuori (2007). This brief expression of empathy preceded a closure of the patient's

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troubles-telling sequence, followed by an immediate shift back to the medical agenda, as previously observed in general practice and homeopathic consultations (Ruusuvuori, 2007). However, this solitary finding implies that a minimally affiliative response is less applicable in the surgical outpatient environment. Consistent with findings of Benwell and Rhys (2018) in pre-operative assessment, the use of a minimal response implies that patients' descriptions of a trouble are not relevant to the medical aims of the consultation at that time, whilst crucially displaying the surgeon's empathy. A solitary finding of minimal affiliation in the current dataset further suggests that surgeons are less likely to empathise with patients in the form of a minimal response. This conclusion is consistent with observations of Ruusuvuori (2007), whereby some patients were found to treat minimal affiliations as insufficient. In such cases, the health professional was required to adopt alternative practices to facilitate a return to the medical agenda, such as extending the interaction (Ruusuvuori, 2007). In the current study, this rejection of minimal affiliation was similarly managed by surgeons' extending their affiliative response to patients' troubles-telling. This finding implies that brief affiliative displays are more difficult to integrate in the context of surgical outpatient consultations than an extended affiliative sequence.

Minimal non-affiliative responses to patients' affective expressions were comparatively, a more consistent feature of the current dataset. Aligned with the classification proposed by Ruusuvuori (2007), these comprised of neutral acknowledgements delivered with falling intonation that served to merely receipt the description of a trouble. Surgeons' non-affiliative responses to patients' expressions of affect were consistent with similar patterns of interaction found in general practice (Suchman et al., 1997). Suchman et al described how an empathic opportunity created by patients' direct and explicit descriptions of an emotional concern, were often terminated by a physicians' response that directed discussion away from the stated affect (1997). The integration of a minimally non-affiliative response in the current

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study implies the equivalent function of this sequence as preventing an ongoing troubles-telling account, allowing surgeons to focus on the institutional objectives of their interaction with patients.

Distinct from Ruusuvuori (2007), a further pattern of interaction emerged in two sequences of the current study as a consequence of minimal non-affiliative responding, evidenced in Excerpts 3 and 4. In both cases, where surgeons failed to affiliate with a troubles-telling account, this non-affiliative response prompted the unfolding of a medically driven line of questioning from patients in their next turn. In both instances, the source of the patients' trouble was related to their medical condition, and their questioning drew upon the surgeons' medical expertise in order to seek further clarification on their condition. This finding suggests that patients may pursue further interaction with surgeons on occasions where they have not received sufficient recognition of their troubles-telling

Extended affiliative responses to patients' troubles-telling were more frequently observed in the dataset, compared to just one instance of minimal affiliation. This finding suggests that surgeons are more likely to affiliate with patients in extended sequences of interaction. In the course of one consultation examined over Excerpts 5 and 6, the surgeon's affiliative response to ongoing troubles talk produced an extended sequence. Consistent with patterns of interaction described by Ruusuvuori (2007), the surgeon exhibited his understanding by displaying knowledge of circumstances relevant to the patient's trouble (Excerpt 5). He then offered a story of his own equivalent experience in Excerpt 6. This interaction demonstrates the comparative ways in which an extended affiliative sequence was produced in this setting to exhibit understanding of a patient's trouble. A further instance of extended affiliation was observed in the interactions of another consultation, evidenced in Excerpt 7. Aligned with Ruusuvuori's (2007) findings again, the surgeon initially claimed affiliation with the patient's troubles-telling in a compassionate expression, followed by a display of knowledge that

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exhibited an understanding of her condition. This pattern reinforces the proposed function of empathy in the literature as bridging a gap between the surgical perspective and the patient's lived experience (Ford et al., 2019). Further aligned with Ruusuvuori (2007), these extended affiliative displays enabled a closure of the troubles-telling sequence before a return to the medical aims of the consultation. In this way, the patients' affective displays were managed as an independent matter from the medical problem at hand. These findings suggest that while extended affiliative responses facilitate greater empathic engagement, the institutional aims of the consultation remain the underlying focus of surgeon-patient interactions. Despite the extended nature of these sequences, the duration of these consultations was not noticeably longer than those in which displays of empathy did not occur. This observation requires further study to be confirmed but implies that extended affiliative responses do not serve as a hindrance to accomplishing the institutional aims of the consultation.

Building upon the classification proposed by Ruusuvuori (2007), extended non-affiliative sequences were notably distinct from their affiliative counterparts in the current study. These were often observed early in the consultation, where patients were describing their clinical problem at the surgeon's request. This suggests that surgeons are less inclined to affiliate with patients' troubles-telling in this initial phase of interaction, at which point they are involved in an institutional task of medical history taking. The differential placement of surgeons' responses to patients' troubles-telling within a sequence of interaction is consistent with previous findings reported in a non-clinical setting (Pudlinski, 2005). In Excerpts 8 and 9, responses of this nature were given to patients' troubles-telling at the point of medical history taking. Consistent with Ruusuvuori's (2007) classification, these non-affiliative extended sequences were primarily concerned with addressing aspects of the patient's health-related problem. With little or no reference to the patients' affective expression, these responses facilitated an immediate shift back to the institutional aims of the consultation,

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without deviating from the medical agenda. This suggests that such a shift can be achieved with a medically driven question from the surgeon, referencing patient's trouble or problem to request further information. These findings reveal the ways in which extended responses are frequently produced by surgeons to manage the troubles-telling of their patients, without engaging in explicit displays of empathy.

4.2 Limitations and future research

In the current study of surgeon-patient interaction, examples of affiliative and non-affiliative responses to patients' troubles-telling did not occur independently of the other, over the course of a consultation. Importantly, this finding suggests that surgeons were not categorically or dispositionally affiliative or non-affiliative in their interactions with patients. The observations of this study must also be considered within the broader context of a public hospital system and the bureaucratic demands that surgeons are obliged to meet. As such, surgeons' attempts to integrate empathy in patient interaction may have been impeded by the institutional context in which they occurred.

It must be further noted that the integration of empathy in surgeon-patient interaction was not restricted to circumstances of a troubles-telling or problem presentation. Affiliative displays were observed in the context of discussion around a recent diagnosis or on occasions in which the surgeon was required to deliver bad news. Non-affiliative responses were produced by surgeons under similar circumstances. In some cases, surgeons were found to display empathy without a preceding troubles-telling. However, as the aim of the current study was to follow an existing framework of surgeons' responses to troubles-telling sequences, these incidental displays of empathy were considered to be outside the scope of this analysis.

The results of this study are limited by the potential for selection bias in the dataset. Participating surgeons were recruited on a voluntary basis and as such, their conduct may not

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be reflective of the wider surgical population. The nature of self-selection is such that participating surgeons may practice empathy more frequently in their interaction with patients. The surgeons and patients involved in the study were also aware that their interactions were being filmed for the purposes of research, which may have had further bearing on their behaviour.

Future research could benefit from a broader focus on the alternative contexts of interaction in which empathy occurs in the course of a surgical outpatient consultation, to examine its function beyond an affiliative response to troubles-telling. Further studies could explore the integration of empathy in other clinical or non-clinical settings of surgeon-patient interaction and consider how this may be achieved by other means, such as non-verbal displays.

4.3 Implications

The current study addresses a gap in the research literature regarding an understanding of empathic communication in the context of surgical outpatient consultations. This research offers insight on the ways in which surgeons routinely respond to patients' descriptions of a trouble or problem. These findings may have implications for the development of surgeons' professional non-technical skills in empathic communication, both during and beyond their medical training. The minimal and extended affiliative sequences of interaction identified in the current study may serve as a teaching point for surgeons in training and practice, to demonstrate the ways in which empathic communication can function in an outpatient environment. The recognition of non-affiliative displays in surgeon-patient interaction is equally important for training purposes, to make surgeons aware of the distinction between a receipt or acknowledgement of troubles-telling in the place of empathy. It is this pattern of non-affiliative responses in the current study that lends further support to the idea of promoting non-technical skills training in the surgical field (Stepien & Barnstein, 2006). The

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formal integration of interpersonal skills-training as a feature of medical education is deemed an effective way to foster empathic communication among graduating medical students (Stepien & Baernstein, 2006). Recent developments towards implementing such programs in surgical residency propose the use of role-play and simulated interaction to improve skills in articulating empathy (Nakagawa et al., 2019). The insights of the current study compliment the current empirical methods used in developing these programs, applying evidence from actual surgeon-patient interactions in the outpatient environment.

4.4 Conclusion

Building upon existing research in this domain, the current study demonstrates the ways in which surgeons routinely respond to patients' troubles-telling in the outpatient environment. Applying the framework proposed by Ruusuvuori (2007) for general practice and homeopathy, to the context of surgical outpatient consultations, enabled a comparison in terms of the routine patterns of interaction observed. The applied use of conversation analysis fostered an understanding of the structural organisation underlying troubles-telling sequences of talk in this institutional setting. These findings contribute to an existing body of literature on empathic communication in the medical encounter, with an emphasis on the lesser known structure of surgical outpatient consultations. Distinct from previous studies of empathy in the medical encounter, the context of surgeon-patient interaction yields troubles-telling sequences that are often the expression of heightened emotion, stress or fear. In managing these affective aspects of the consultation, surgeons are required to work within the bureaucratic constraints of a public hospital environment. The current findings demonstrate the ways in which this balance of competing interests can be achieved.

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Appendix A

CALHN HREC Amendment Approval

HREC reference number: [REDACTED]

CALHN reference number: [REDACTED]

Project title: Surgical Coaching in the Outpatient Environment – A Video-Based Intervention.

CPI: Prof Guy Maddern

Please accept this e-mail as **Acknowledgement of Receipt, Review and APPROVAL** of the document(s), on behalf of **Central Adelaide Local Health Network Human Research Ethics Committee (CALHN HREC) and CALHN Research Governance**, and retain a copy for your records.

Approval is effective from the date of this email. For multi-centre studies a copy of this email must be forwarded to Principal Investigators at every site approved by the CALHN HREC for submission to the relevant Research Governance Officer along with a copy of the approved documents.

<i>Document</i>	<i>Version</i>	<i>Date</i>
Protocol SCOPE (clean and tracked)	1.4	24 June 2018

This approval is subject to the conditions outlined in the original ethics approval letter.

Should you have any queries about this matter please contact the Executive Officer of the HREC on [REDACTED]
Health.CALHNResearchEthics@sa.gov.au

Kind regards

CALHN Research Services

for

Mr Ian Tindall
Chair, Human Research Ethics Committee
Central Adelaide Local Health Network



Government of South Australia

SA Health

Central Adelaide Local Health Network Inc.

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Appendix B

Human Research Ethics Approval Notification Declaration

Human Research Ethics Approval Notification Declaration

I/we accept responsibility for the conduct of this research project in accordance with the [National Statement on Ethical Conduct in Human Research \(2007\)](#), the [Australian Code for the Responsible Conduct of Research](#) and the [University's Responsible Conduct of Research Policy](#).

I/we agree to notify the University of Adelaide's Human Research Ethics Committee in writing in the event of any adverse or unforeseen events, amendments to the approved protocol that may alter whether this notification can be accepted by the University, changes to the approval end date, at project completion and of any changes to research personnel.

Primary University of Adelaide Contact Signoff:*

1	ID	██████████
	Type	Internal
	Full Name	Hender, Phoebe Rose
	Position	Associate Investigator
	Declaration signed?	Yes
	Signoff Date	29/07/2019

Outcome

Review Outcome

This page provides the outcome of the reviews by the Human Research Ethics Secretariat and Insurance Office.

Outcome of Review of Notification Form:

**Accepted: The University of Adelaide has accepted this notification of Human Research Ethics Committee approval(s).
The University of Adelaide's involvement will be indemnified by The University of Adelaide's insurance(s).**

Project Title:

Surgical Coaching in the Outpatient Environment – A Video-Based Intervention

University of Adelaide Notification Reference Number:

██████████

Appendix C

Transcription Notation

The following transcription symbols are based on the Jefferson Transcription System for Conversation Analytic Research (Jefferson, 2004).

- [*A left bracket* indicates the point of onset at which the current speaker's talk is overlapped by the talk of another.
-] *A right bracket* indicates the point at which two overlapping utterances end, if they end simultaneously, or the point at which one of them ends in the course of the other.
- (0.1) *The number in parentheses* indicates time elapsed in tenths of a second.
- (.) *A dot in parentheses* indicates a brief interval (less than a tenth of a second) within or between utterances.
- *A dash* indicates cut-off speech.
- >word< *Speech within inverted arrowheads* indicates that the bracketed utterance is sped up compared to the surrounding talk.
- <word> *Speech within protruding arrowheads* indicates that the bracketed utterance is slowed down compared to the surrounding talk.
- <word *A pre-positioned left arrowhead* is a 'left push', indicating a hurried start in speech.
- word< *A post-positioned left arrowhead* indicates that while a word is fully completed, it seems to stop suddenly.
- (h) *A parenthesized 'h'* indicates plosiveness. This can convey laughter, crying or breathlessness.
- .hhh *A dot-prefixed row of 'h's* indicates an inbreath.
- hhh *A row of 'h's without a dot,* indicates an outbreath.
- wohhrd *A row of 'h's within a word* indicates breathiness.
- wghord *A 'gh' within a word* indicates gutturalness.

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- = *Equal signs* indicate no break or gap.
- A pair of equal signs* at the end of one line and one at the beginning of a next, indicates no break between the two lines.
- A single equal sign* indicates no break in an ongoing piece of talk, where one might otherwise expect it.
- *Underscoring* indicates some form of stress, via pitch and/or amplitude. A short Underscore indicates lighter stress than does a long underscore.
- :: *Colons* indicate the prolongation of the immediately prior sound. The longer the row of colons, the longer the prolongation.
- :_ *Combinations of underscore and colons* indicate intonation contours as per the following examples:
- wo:rd → If a letter preceding a colon is underscored, the sound represented by that *letter* is ‘punched up’. Therefore, an underscored letter followed by a colon indicates an ‘up-to-down’ pattern.
- w:rd → If the colon is underscored, then the sound at the point of the *colon* is ‘punched up’. Therefore, a letter followed by an underscored colon indicates a ‘down-to-up’ pattern.
- wo:rd → If underscoring occurs prior to the vowel preceding the colon, then the *entire word* is ‘punched up’, the colon indicates prolongation only, there is no mid-word shift in pitch.
- In *multi-syllabic* words, if the consonant is underscored, then all syllables thereafter are ‘punched up’.
- ↑↓ *Arrows* indicate shifts into especially high or low pitch.
- .,? *Punctuation markers* are used to indicate ‘the usual’ intonation.

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- °word° *Degree signs* bracketing an utterance or utterance-part indicates that the sounds are softer than the surrounding talk.
- * *An asterisk* indicates percussive non-speech sounds.
- £ *The pound-sterling sign* indicates a certain quality of voice which conveys ‘suppressed laughter’.
- (()) *Doubled parentheses* contain the transcriber’s descriptions.
- [15: 75] *Headings enclosed in square brackets* refer to the specific patient consultation number (15) out of the entire corpus of video-recordings (75).
- () *Empty parentheses* indicate that the transcriber was unable to understand what was said. The length of the parenthesized space reflects the length of the talk, relative to the surrounding talk.