

The Language of Clinical Empathy:

Modelling affiliation in doctor-patient
communication

Olivia Watson

A thesis submitted in partial fulfilment of the
requirements for the degree of

Bachelor of Arts (Advanced) (Honours)

Department of Linguistics
Faculty of Arts and Social Sciences
The University of Sydney

November 2012

Contents

Acknowledgements	3
Transcription conventions	4
Chapter 1: Interpersonal communication in medicine	6
1.1 Benefits of good medical communication	6
1.2 The need for improvement	7
1.3 Clinical empathy: a target issue	8
1.4 The language of clinical empathy	11
Chapter 2: Theoretical background and approach	12
2.1 Systemic Functional Linguistics	12
2.1.1 APPRAISAL theory	13
2.1.2 Affiliation and communing: negotiating interpersonal bonds	17
2.1.3 Other affiliation strategies: deferring bonds with laughter	18
2.2 Intonation	20
2.3 Teaching communication and empathy	21
2.3.1 Interpersonal skills in medical education	22
2.3.2 Medical models of empathy	24
2.3.3 Modelling medical empathy through APPRAISAL	26
2.4 Data and methodology	29
Chapter 3: Responding to empathic opportunities	31
3.1 Patient/kin expressions of empathy	32
3.2 Graded model of doctors' empathic responses	33
3.2.1 LISTEN	35
3.2.2 ACKNOWLEDGE	38
3.2.3 SUPPORT	39
3.2.4 ACCORD	42
3.2.5 VALIDATE	44
3.2.6 SHARE	45
3.3 Non-empathic responses	46

3.3.1 DEFER (laughing affiliation)	47
3.4 Conclusion	50
Chapter 4: Empathic responses in context: patterns in use	51
4.1 Responses in individual bonding exchanges	51
4.1.1 LISTEN	52
4.1.2 ACKNOWLEDGE	52
4.1.3 SUPPORT	54
4.1.4 ACCORD	56
4.1.5 VALIDATE	57
4.1.6 SHARE	58
4.1.7 Laughing affiliation: deferring unshared potential bonds	60
4.2 Empathy as a bonding exchange complex: logogenesis	68
4.2.1 Increasing emotion receiving increasing empathy	69
4.2.2 Initial high empathy subsequently fluctuating during elaboration	75
4.3 Summary: what are the 'ideal' doctor responses?	78
Chapter 5: Conclusions, implications and further directions	80
5.1 Summary of findings	80
5.2 Potential implications in medical education	82
5.3 Potential implications in linguistics	85
5.4 Future directions	86
References	89
Appendix	
Recognition of external ethics approval	94

Acknowledgements

This project evolved as a bridge between undergraduate linguistics and postgraduate medicine: applying linguistic analysis of medical interaction to gain a better understanding of effective communication, partly to improve my own professional skills. As a future medical student and doctor, I am concerned by the issues overtly present in societal opinions of medical communication, and determined to ensure successful empathic and interpersonal skills remain a priority for me. I also believe further cross-disciplinary study with linguistics could have great benefits for healthcare, and certainly intend to stay involved.

I owe my thanks to the families I meet each week at Ronald McDonald House, Randwick, whose stories about their hospital experiences - the good and the bad - provide a constant reminder of why communication is so important in medicine. They have taught me about the emotional trauma and anxiety caused when, on top of the struggle with serious illness, patients and families also do not feel supported by the hospital staff. They have also revealed the immense comfort a better doctor-patient relationship can provide. Their stories have motivated me to pursue this topic not only for research interest but also to better understand how I can communicate as effectively as possible when I am a doctor myself.

Thanks are also well due to the doctor involved in this study, for his generosity with time and knowledge, and his true interest in interdisciplinary work between linguistics and medicine. This is the sort of collaboration necessary if the healthcare profession is to benefit from the insight into interaction that language analysis can provide; facilitation of projects such as this one is a significant step in this direction. To Lynda Yates, Peter Roger and the rest of the CHAMP project team: thank you for your assistance in organising data collection and generally for supporting this student project.

Thank you especially to the rest of my Honours cohort this year, in Linguistics and beyond: for sharing the fun and because you understand best. And a huge thank you to all the friends and family who have patiently feigned interest through many enthusiastically over-detailed explanations of my research this year: if I were to assess your communication of empathy you would pass with flying colours.

Finally, and most importantly, I am enormously grateful to Jim Martin for his thoughtful and supportive supervision, for his patience, and for his unfailing linguistic wisdom. It has been a real privilege.

Transcription conventions:

The transcriptions in this thesis follow simple, purpose-based conventions that aim to present the relevant information clearly. They do not overcomplicate the display of text, allowing long extracts to be easily readable, and the necessary information readily identifiable. As presented below, this thesis uses some symbolic representations and comments to code aspects of the speech, along with numerical representations of empathic responses (from the model proposed in chapter 3) and colour coding of the APPRAISAL system.

D doctor
P patient
W wife of patient

xxx unintelligible speech
= simultaneous speech
[fall] intonation contour (fall, rise-fall etc)
[laugh] laughter
[laughing] simultaneous speech and laughter

1 empathic response code (1-6: see chapter 3)

Inscribed ATTITUDE:

AFFECT, **JUDGEMENT**, **APPRECIATION**, **GRADUATION**

Invoked ATTITUDE:

AFFECT, JUDGEMENT, APPRECIATION

Chapter 1: Interpersonal communication in medicine

Effective communication is increasingly recognised as vital to successful delivery of medical services across all domains of healthcare; but it is also an area in which skills are lacking and further education is required. The significance of good communication in medicine has long been established (e.g. Slade *et al.* 2008; Ihler 2003; Gask & Usherwood 2002; Cegala & Broz 2002). As Levinson and Pizzo explain, 'excellent medical care combines sophistication in scientific knowledge with equally sophisticated communication skills to understand the needs of the individual patient, to address his/her feelings and concerns with sensitivity and compassion, and to educate patients about their choices in care' (2011:1802).

The notion that doctors are poor communicators is not new or uncommon, with empirical findings supporting the anecdotal evidence of poor social skills, empathy or patient understanding (Levinson & Pizzo 2011:1802). In fact, the majority of patient criticism of healthcare professionals relates to their communication or interpersonal skills, and not to their medical knowledge and abilities (Buckman *et al.* 2011; Slade *et al.* 2008). Over the last three to four decades medical communication has become a larger focus of health research and education, yet it is still considered to need considerable improvement in its development, implementation and also assessment (Levinson & Pizzo 2011; Cegala & Broz 2002:1004). This thesis targets empathy, a major aspect of doctors' interpersonal skills. It explores empathy from a linguistic perspective, focusing on the ways in which doctors can display empathy in a consultation. In particular, it considers how patients express concerns, and how doctors can demonstrate empathy when responding to these concerns. Overall, it examines the language of medical empathy, aiming to build on the existing strategies in health education by providing further information about the linguistic characteristics of successful interpersonal communication.

1.1 Benefits of good medical communication

As Slade *et al.* explain, good communication and interpersonal skills 'have long been recognised as fundamental to the delivery of quality health care' (2008:271). The benefits largely relate to

increased patient satisfaction: where the patient feels they have been treated thoroughly and appropriately, have had all their concerns addressed and are satisfied the doctor has cared enough about their treatment to comprehensively follow through to the best outcome (e.g. O'Keefe 2001). Particular correlations have been found with satisfaction regarding the patient-centredness of their treatment (Ishikawa *et al.* 2005) and also continuity of care (Slade *et al.* 2008:274), which is where patients perceive they are recognised and cared for through multiple visits (Cook *et al.* 2000). This patient satisfaction is beneficial to the relationship between the patient and the doctor or facility, and has flow-on effects in other aspects of the medical outcome.

Successful interpersonal communication has been shown to lead to increased understanding of treatment (Edwards & Elwyn 2001), for example as a good relationship with the doctor encourages the patient to ask more clarifying questions or offer more relevant information. This is supported by Kim *et al.*'s (2004) findings that good communication leads to increased patient adherence to instructions and hence a more successful medical outcome. Further, Sator's (2008) study of doctor-patient communication in oncology departments identified how the degree of attention the doctor pays to issues relevant to the patient is proportional not only to satisfaction, but also to the efficiency and quality of the medical treatment. It is therefore clear that effective communication plays a vital role in healthcare and that any areas needing improvement ought to be addressed.

1.2 The need for improvement

While the aforementioned benefits are now well known, there apparently remains a considerable amount of room for improvement in the actual practice and teaching of clinical communication (Levinson & Pizzo 2011; Cegala & Broz 2002:1004). It is commonly said that doctors lack adequate interpersonal skills (e.g. Buckman *et al.* 2011) and there is much anecdotal evidence in society about patients' dissatisfaction with their interpersonal treatment, including internet review websites that 'abound with criticisms about physicians' deficiencies in communication skills' (Levinson & Pizzo 2011:1802). Researchers and educators in the healthcare field have devoted an increasing amount of attention to this area as over the last few

decades it has become acknowledged as a significant area for improvement (Levinson & Pizzo 2011; Ihler 2003; Cegala & Broz 2002).

In particular, there is a need for improvement of the identification of patients' less direct expressions of concern: rather than stating them directly, patients frequently hint to relevant issues using 'interactional markings of relevance' such as changing volume or speech patterns, hesitation or metaphors (Sator *et al.* 2008). Although such behaviour is common, evidence has shown doctors often do not pay enough attention to these clues, thus opportunities for building rapport are missed (Sator *et al.* 2008; Ruusuvaori 2007).

In another study of the impact communication can have on medical outcome, Britten *et al.*'s research on patients' comprehension of instructions revealed 80% of the prescriptions analysed were misunderstood in some way, due to ineffective communication (2000). That is, due to various forms of miscommunication many patients in this study would not have taken the exact treatment their doctor intended for them and thus would not undergo the optimal recovery. This clear correlation with medical outcome demonstrates the significance of successful doctor-patient communication.

To summarise, patients' perceptions of physicians' communication and empirical findings of missed opportunities and misunderstandings provide considerable evidence that doctors' interpersonal skills still need improving. Since effective communication is linked with positive medical outcomes, for example through patient satisfaction, understanding of treatment and adherence to instructions, these issues should be further addressed.

1.3 Clinical empathy: a target issue

Representation of empathy is an element of interpersonal communication with significant impact in optimising patient satisfaction, as well as physical medical outcome through understanding and adherence (Epstein *et al.* 2007:1732). It is also a skill identified as needing improvement, and an area to which much of the criticism from patients, families and society in

general, is directed (e.g. Buckman *et al.* 2011; Finset 2010; Sator *et al.* 2008; Ruusuvuori 2007; Suchman *et al.* 1997).

Commonly referred to as a necessary but often missing skill (e.g. Buckman *et al.* 2011; Sator *et al.* 2008), the term 'empathy' in the context of medical communication is used to refer to the ability to recognise and understand the patient's experience and the emotions associated with it: in this context empathy is not about the doctor's feelings, but how he/she demonstrates this understanding to the patient (Bylund 2001:60). This follows from prominent empathy analysis introduced by Truax and Carkhuff in 1967 (the 'Accurate Empathy Scale'), which defines the sort of empathy discussed in health professional fields as concerning 'sensitivity to current feelings' and 'verbal facility to communicate this understanding in language attuned to the client's current feelings' (1967:46). They explain that this 'accurate empathy' (including both internal feelings of empathy and external empathic communication) does not include actually feeling the patient's emotions, which they claim is undesirable (Truax & Carkhuff 1967:). Extended from this definition, the term 'clinical empathy' (see Buckman *et al.* 2011; Neumann *et al.* 2009) is used in this thesis to refer to this empathic understanding conveyed by doctors in the consultation setting, and all discussion of 'empathy' here refers to this 'clinical' or 'accurate' (Truax & Carkhuff 1967) empathy.

Clinical empathy is indeed a skill that can be taught, as has been shown by Buckman *et al.*'s analysis of medical students' improvement in responding to patient concerns (2011). The present issue then extends beyond the need to recognise empathy's significance, to the question of how empathic communication can be taught. Despite its proven importance, empathy is a complex phenomenon and difficult to define, measure and teach (Pounds 2011:140). There is currently no standard model for understanding, teaching or assessing clinical empathy, though numerous models do exist (mostly for assessment purposes), such as the Roter Interaction Analysis System (RIAS; see Roter & Larson 2001), the Four Habits for Clinical Success model (FHCS; Frankel & Stein 1999) and the Empathic Communication Coding System (ECCS; Bylund 2001). These will be discussed in chapter 2.

Very little of the work in clinical empathy has been undertaken from a linguistic perspective, and so the models and teaching strategies that do exist are not grounded in explicit, systematic

language criteria that define effective empathic communication (e.g. see Pounds 2011; Sandvik *et al.* 2002). Existing strategies have been successful in identifying and categorising many examples of good and bad empathic communication, but often remain quite tokenistic. That is, they are frequently limited to specific examples, for instance ‘empathic phrases’ such as *I understand how important it is for you to get back to work* (Segal 1995:1067), feedback that encourages the patient to continue expressing their experience (e.g. *go on* or nodding: Gask & Usherwood 2002:1568), and the use of open-ended *wh-* questions instead of polar *yes/no* interrogatives (FHCS: Frankel & Stein 1999).

Ihler explains that the actions constituting effective communication are ‘still vaguely defined’ in medical literature, prompting increased interest in refining them to promote better doctor-patient rapport (2003:92). The existing strategies certainly do provide some insight into how doctors can effectively communicate empathy, and indeed have been proven to be useful for improving medical communication (Buckman *et al.* 2011). Yet they are limited in not being able to account for all the potential ways in which doctors can express empathy. As Pounds explains, ‘no systematic overview of the potential verbal realisation of empathy has so far been produced’ (2011:139). Pounds’ paper proposes one such overview, using the APPRAISAL system (Martin & White 2005) to ‘build a provisional framework of the levels of attitudinal (particularly, affective) expression inherent in empathic communication’ (2011:139), although this model is purely theoretical and not based on actual interactional data.

This thesis takes a similar angle of analysis, building on Pounds’ proposed framework to explore the relationship between attitudinal expression and empathy with respect to systems of APPRAISAL and AFFILIATION (these systems are introduced in chapter 2) in order to add linguistic information to the existing communication strategies taught in medical training. It aims to develop and refine understanding of successful doctor-patient interaction settings by looking more closely at the language that construes clinical empathy.

1.4 The language of clinical empathy

Approaching the issue from a linguistic perspective can target the reasons why expressions are empathic or not, by identifying the language criteria behind them. This understanding can then lead to a better ability to create such expressions: teaching doctors the language criteria for communicating empathy will allow them to be productive in using new expressions of their own, building on the examples currently taught to allow infinite creative potential.

This thesis aims to investigate the language of clinical empathy: how doctors can use language to build rapport. It will take existing work on clinical empathy to a finer level of analysis, looking at the linguistic characteristics of empathic interaction and identifying criteria for expressions of differing degrees of empathy. Rather than focussing on using a model of clinical empathy to assess doctors' performance, as most existing models are designed to do (e.g. ECCS, RIAS), this thesis aims to help doctors understand how they can use language to communicate effectively, by looking at the language deployed by a successful medical empathic communicator. That is, it focuses on one expert to give a qualitative analysis of the language strategies he uses in building rapport. It proposes a model of clinical empathy based on this case study and informed by previous work, both empirical (e.g. Bylund & Makoul 2002; Levinson *et al.* 2000) and theoretical (e.g. Pounds 2011). This model describes the options doctors have in responding to patients' concerns with varying degrees of empathy, the linguistic features behind these different responses, and patterns in their use in terms of when the different levels may or may not be appropriate in the consultation dialogue.

The crux of this issue is not that the interpersonal strategies taught in medical communication education are incorrect, but that they are not comprehensive. Utilising a linguistic framework to analyse examples of good communication can help by identifying linguistic characteristics of empathy. This thesis offers insight into the potential to develop a model of empathic communication grounded in definable language categories. This then has potential to improve education by providing a clearer framework for understanding why expressions are empathic to different degrees, and thus help doctors understand how they can use their language to communicate effectively with their patients.

Chapter 2: Theoretical background and approach

Chapter 2 introduces the theoretical background underpinning this research and summarises the existing literature in the area of medical communication training. Section 2.1 introduces systemic functional linguistics, in particular the APPRAISAL system and its application in analysing systems of affiliation and bonding. The study of intonation and its use in making meaning is then discussed in section 2.2. Following this is an overview of communication skills training in medicine, including existing models of clinical empathy and how a linguistic perspective could benefit the current understanding. Finally, section 2.4 introduces the data and methodology used in this thesis to present a linguistic model of effective empathic communication.

2.1 Systemic Functional Linguistics

The theoretical background to this research is systemic functional linguistics (SFL), as developed by Halliday and colleagues (e.g. Halliday 2004/1994). SFL considers language in terms of its function in social context – interpreting meaning as created through social interaction and viewing language as one of the main ways in which meaning is made (Halliday 1978). In SFL theory, language is analysed in relation to the context in which it is used and the meanings it negotiates within that context.

Halliday's theory divides language into three dimensions – the ideational, textual and interpersonal 'metafunctions' – all of which are inherent in the system of language; thus all three kinds of meaning are created concurrently in discourse (1978). These metafunctions are realised through simultaneous systems of lexicogrammar, which map to systems of meaning (in discourse semantics), and then to dimensions of social context (or 'register'), as illustrated in Figure 2.1 below (see Halliday 1978).

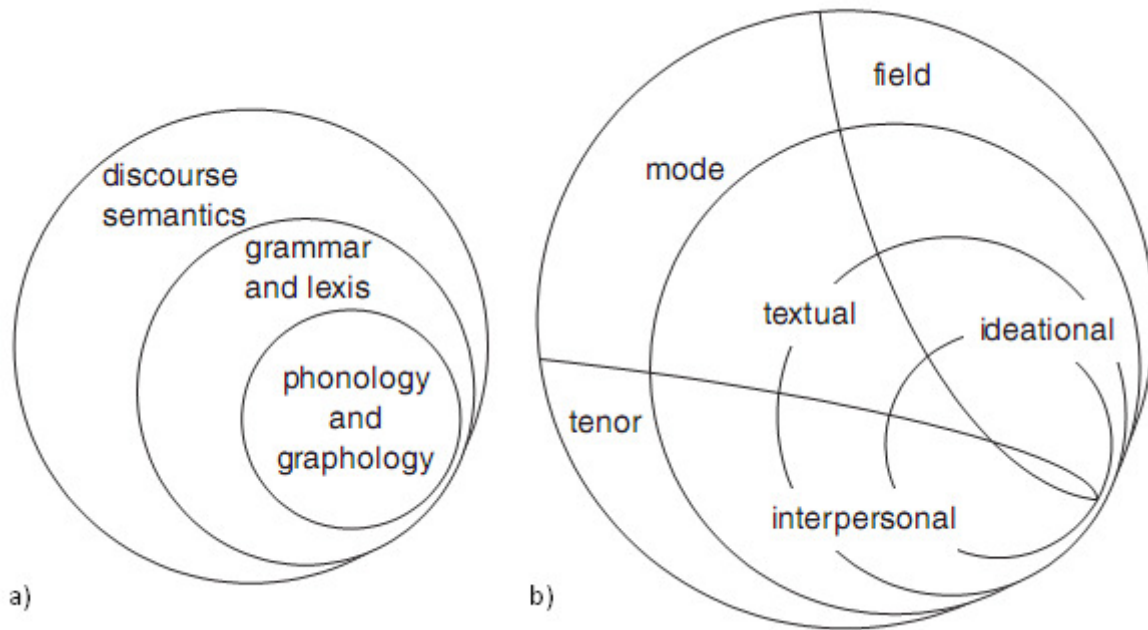


Fig 2.1: (a) Stratified system of language and (b) the overlying three systems of meaning realised at all of these levels, as well as at the additional level of social context comprising field, tenor and mode (Martin & White 2005:9,27)

The ideational metafunction is concerned with the experiences construed in the text – its events and participants – and the logical relations between them. Textual meaning is created in the composition and flow of information through the text itself. Finally, the interpersonal metafunction negotiates the relationships between participants inside and outside the text, which are construed through systems of NEGOTIATION and APPRAISAL (see Martin & White 2005). The APPRAISAL system (interpersonal metafunction) is introduced below, as it underpins the theory of bonding informing this study. Analysis in this thesis will largely focus on the ideational and interpersonal metafunctions and their interaction, following Knight's (2010) theories regarding bonding (see section 2.1.2).

2.1.1 APPRAISAL theory

On the level of discourse semantics, APPRAISAL is a system developed by Martin and White (2005) as a framework for analysing evaluative meaning. This thesis takes an SFL-based approach to

analyse the empathic exchanges between doctors and patients in a consultation, using theories of bonding developed in SFL by Martin (e.g. 2008; also see Martin & Stenglin 2006) and Knight (2010) (introduced in section 2.1.2) that are underpinned by the APPRAISAL system described here.

APPRAISAL theory provides a framework for analysing interpersonal meaning and the negotiation of relationships within a text. APPRAISAL analysis identifies the positive and negative attitudes presented, how these attitudes are intensified (graded) and from which participant they are sourced. These form the three APPRAISAL subsystems, called ATTITUDE, GRADUATION and ENGAGEMENT. This framework allows for investigation of the ways in which ‘writers/speakers approve and disapprove, enthuse and abhor, applaud and criticise, and with how they position their readers/listeners to do likewise’ (Martin & White 2005:1).

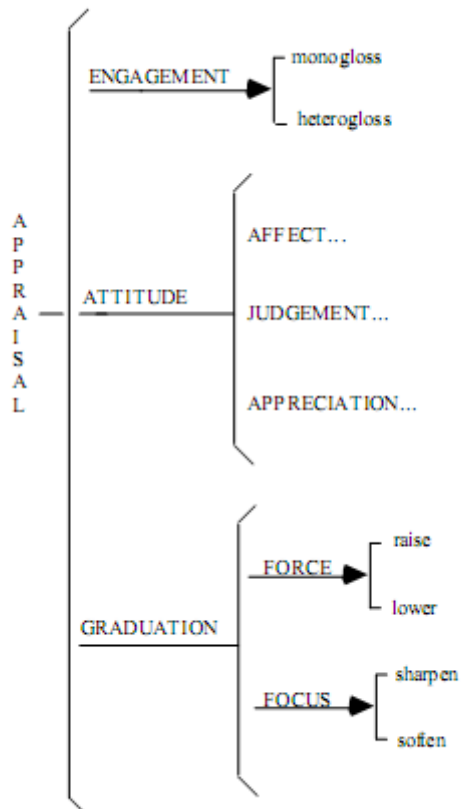


Fig 2.2: APPRAISAL system network (Martin & White 2005:38)

The first subsystem, ATTITUDE, is divided into three further subcategories: APPRECIATION of objects, JUDGEMENT of people and AFFECT (expressions of emotion) (Martin & White 2005). For example, *that useless assignment* is negative APPRECIATION, ‘my friendly teacher’ is positive JUDGEMENT, and *he was anxious* is negative AFFECT. AFFECT, JUDGEMENT and APPRECIATION each have further subsystems, but finer categorisation is not required in the identification of evaluative couplings in this thesis. The second subsystem, GRADUATION, is the study of how the FORCE or FOCUS of attitudes are increased or decreased – for example, *very friendly* is raised FORCE (amplification of attitude), and *kind of blue* is softened FOCUS (blurring of categories) (Martin & White 2005:35). Lastly, ENGAGEMENT examines the interplay of voices in a text – identifying how different expressions of attitude are presented and how speakers present their stance towards the attitude by clarifying its source (Martin & White 2005:97). ENGAGEMENT considers the use of monoglossia vs. heteroglossia: monogloss does not acknowledge alternative perspectives (the speaker speaks with one voice; e.g. *Richard came home at three-fifteen*), whereas heterogloss acknowledges other views, through projection (e.g. *Richard says he came home at three fifteen / I think he came home at three fifteen*), modality (e.g. *Richard might have come home at three fifteen*) or concession (e.g. *however Richard came home at three fifteen*) (this model of ENGAGEMENT is from Martin & Rose 2007, somewhat simplified from Martin & White 2005). Table 2.1 summarises the subsystems of APPRAISAL and how it applies as an analytical framework:

Subsystem	Analytical categories	Description	Example
ATTITUDE	APPRECIATION	opinion of things	<i>useless</i>
	JUDGEMENT	opinion of people	<i>friendly</i>
	AFFECT	feeling/emotion	<i>anxious</i>
GRADUATION	FORCE: increase/decrease	grade strength of attitude	<i>very, extremely, rather; quite, slightly</i>
	Focus: sharpen/soften	blur category boundaries to make something gradable	<i>totally, absolutely; kind of, sort of</i>
ENGAGEMENT	Monogloss	no other voices acknowledged	<i>John left; It was cold</i>
	Heterogloss:	other voices acknowledged:	
	- projection	directly, by reporting	<i>Bill said “...”</i>
	- modality	by modalising probability, usuality, obligation, inclination or ability (includes negation)	<i>maybe, sometimes, can, should, must, no(t)</i>
	- concession	in process of refuting another perspective	<i>although, yet, but</i>

Table 2.1: Summary of the APPRAISAL system and its analytical framework (see Martin & White 2005).

Attitudes can be presented explicitly ('inscribed') or implicitly ('invoked'). The diagram below illustrates how speakers can choose how explicitly to present attitude: by inscribing it directly (naming the attitude), or invoking it – and there are further degrees of explicitness within the 'invoke' options (Martin & White 2005:67).

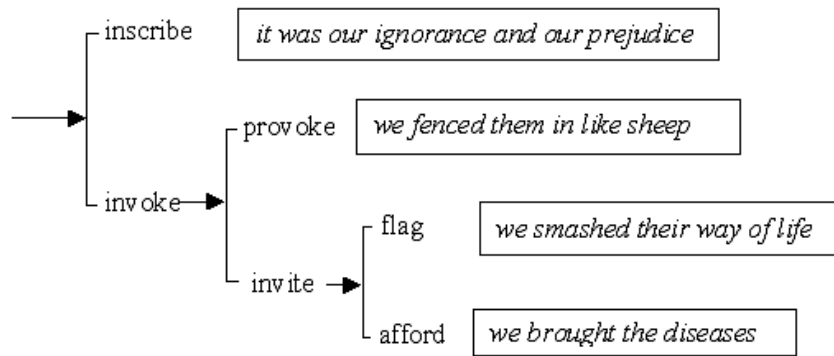


Fig 2.3: Inscribed and invoked Appraisal (Martin & White 2005:67).

As Hood and Martin (2006:746) explain, attitudes can be inscribed directly in words, or invoked through lexical metaphor ('provoke'), the GRADUATION system ('flag'), or just the ideational content ('afford'). Martin and White also discuss the idea that JUDGEMENT and APPRECIATION have evolved from AFFECT, as feelings that are 'institutionalised' or 'reworked' into values (2005:45). Having emotion underlying other attitudes suggests these inscriptions could also invoke AFFECT, if the emotion behind the insititutionalised feeling can still be recognised; this is further discussed in section 4.2.1.

As explained below (section 2.1.2), attitudes make up one half of the 'evaluative couplings' used to propose bonds in discourse, the other half being the ideational content to which the attitude is directed (Knight 2010:69). This thesis uses the ATTITUDE and GRADUATION systems to identify and examine empathic exchanges; the potential for further insight through ENGAGEMENT analysis is discussed in section 5.4. Following Knight's transcription conventions (2010:xi), inscriptions of **AFFECT** will be highlighted in red, **JUDGEMENT** in green, **APPRECIATION** in blue and **GRADUATION** in pink. Invoked expressions will be underlined rather than highlighted, following the same colour-coding scheme.

2.1.2 Affiliation and communing: negotiating interpersonal bonds

This thesis focuses on doctor-patient empathic exchanges, analysing instances where patients express attitude toward some experience and doctors may respond to negotiate this expressed emotion or value. Stenglin's concept of 'bonding' (2004) and further work on affiliation within SFL (e.g. Martin & Stenglin 2007; Knight 2010) are used here as a basis for analysing these exchanges and how doctors and patients can 'commune' around values they express.

Stenglin describes bonding as an interpersonal tool concerned with 'communings': 'ways of building togetherness, inclusiveness and affiliation' (2004:402). In language, study of bonding concerns the ways in which language can align people into communities of 'attitudinal rapport' – shared feelings (Martin 2004:323). Since bonding is dependent on the negotiation of feelings, SFL research has often deployed the APPRAISAL analytic framework (introduced above in section 2.1.1) to investigate the representation and sharing of attitudes in language (Stenglin 2004:402-403).

SFL-based studies of affiliation identify bonding as a phenomenon that brings together the interpersonal and ideational meanings in a text to allow participants to commune around shared values (Martin & Stenglin 2007). As Martin and Stenglin describe, the 'basic function' of bonding is 'to align people into groups with shared dispositions' (2007:216). Bonds are created when interactants share couplings of attitude and ideation – that is, one participant in a conversation proposes an attitude about something (the target/trigger of the attitude – see Martin & White 2005) and another participant shares this value (Knight 2010:70). Martin's work on the negotiation of affiliation through APPRAISAL has shown how shared AFFECT aligns people around emotion, shared JUDGEMENT aligns people around character or principles, and shared APPRECIATION around what Bourdieu refers to as taste (2004:329). When these feelings and views are negotiated successfully, people are thus aligned 'in relation to shared values' (Stenglin 2004:403).

2.1.3 Other affiliation strategies: deferring bonds with laughter

Knight extends existing work on affiliation and bonding, stating that different responses to evaluative couplings (attitude + ideation) can lead to different kinds of affiliation than just the communion enacted when the couplings are shared (2010:71). She introduces the notions of ‘laughing affiliation’ and ‘condemning affiliation’ in addition to the existing ‘communing affiliation’ discussed in section 2.1.2 (2010:217). Through these strategies, participants can align themselves not only by sharing a bond, but also by laughing about an unshared potential bond (‘laughing affiliation’) or rejecting an unshareable potential bond (‘condemning affiliation’), thus communing around an alternative, implicated bond (see Knight 2010:217-234 and Table 2.2 below).

Affiliation strategy	Communing	Laughing	Condemning
Response to proposed bond	Sharing of bond	Deferring unshared potential bond; communing around an implicated bond	Rejecting an unshareable potential bond to commune around a shared bond
Reason for response to bond	Proposed attitude + ideation coupling can be shared as a communal value	Proposed bond creates non-threatening tension; laughter defers this intruding bond in favour of an implicated bond they can commune around	Proposed bond violates participants’ shared bonds; rejecting it together reinforces existing bonds

Table 2.2: Strategies of affiliation (adapted from Knight 2010:217).

Although most attention will be paid to ‘communing affiliation’ in this thesis (in order to analyse the ways doctors can respond empathically to patients’ concerns), the deferral of bonds through ‘laughing affiliation’ is also an interesting phenomenon that will be considered. Despite research into its role in everyday conversations, the function of laughter in doctor-patient interaction has yet to be widely studied (Alasuutari 2009:107). Laughter is not uncommon in institutional settings; however it is usually used by the patient/client and is rarely reciprocated by the doctor/professional (Alasuutari 2009; Haakana 1999). Since it occurs in similar patterns in the consultations of this analysis, and frequently in situations of empathic exchanges, laughter’s role in the negotiation of bonds will also be investigated (see chapter 4.3).

In the first detailed study of laughter in a medical institutional setting, West (1984) claimed that the asymmetrical use of laughter in medical consultations reflects the unequal power levels and social distance of medical communication. West argues that by choosing not to laugh with the patient, doctors elect to sustain their superordinate position (1984:127). However Haakana's further analysis of the patterns in patients' use of laughter indicates that it is used not as a sign of 'humour' or 'amusement', as described by West, but rather an accompaniment to 'various types of delicate activity' (2001:189). Its interactional function in these problematic or awkward situations can thus be seen to follow Knight's concept of 'laughing affiliation' (2010), as it is used to 'laugh off' unshared potential bonds that create tension in the doctor/patient relationship.

Knight proposes 'laughing affiliation' to describe the way that participants laugh off the non-threatening tension ('wrinkle') created by an 'intruding potential bond' so that they can affiliate around an alternative bond that does not create affiliative tension (2010:221). The evaluative coupling that is presented (the proposed bond) creates 'a laughable wrinkle' and an alternative bond that they can commune around is implicated beneath the humour; when this wrinkle is laughed off the proposed bond is deferred, and the interactors defer to the implicated bond (Knight 2010:221). Knight illustrates this with the example of some friends talking about eating too much over the holidays: when a speaker presents positive appreciation of eating a lot ('I ate well'), they laugh off the potential 'Happy Fatness' bond (although they may have communed around it in other contexts such as with their families during the holidays) and instead commune around an alternative 'implicated bond of being thin and beautiful' as this is something the young female students can rally around (2010:227).

Analysis of bond negotiation will underpin the investigation of doctor-patient empathic exchanges in this thesis. Drawing upon APPRAISAL theory, it will identify evaluative couplings proposed by the interactors and the ways in which these proposed bonds can be shared or deferred to enhance interpersonal rapport.

2.2 Intonation

Another significant element of the analysis in this thesis is the study of intonation, which is important for differentiating the back-channel responses doctors give to patient expressions. Back-channels (called ‘response tokens’ in Gardner 2001) are minimal responses, usually mono- or bi-syllabic, that ‘control turn-taking, the negotiation of agreement, signalling of recognition and comprehension, management of interpersonal relations such as control and affiliation, and the expression of emotion, attitude and affect’ (Ward 2006:114). Back-channel utterances have been studied quite thoroughly, particularly *yeah* and *mm* (Lambertz 2011:12). Responses such as these have been shown to be ‘exquisitely complex’, with multiple functions available (Gardner 2001:1), and with their various uses often being difficult to distinguish (Lambertz 2011:16). Gardner’s study of some of the most common back-channels in English describes how intonation analysis can be applied to help make these distinctions, as the ‘intonational shape of these tokens differs systematically with the way they are used’ (2001:129). He divides eight main response tokens into four classes: continuers, acknowledgement tokens, newsmakers and ‘change of activity’ tokens (2001), as illustrated in Table 2.3 below.

Back-channel class	Function	Examples
Continuers	Show listening but allow speaker to continue talking	<i>mm hm, uh huh, mm</i> [fall-rising]
Acknowledgement tokens	Demonstrate agreement or comprehension	<i>yeah, mm</i> [falling]
Newsmarkers	Mark the previous turn as newsworthy	<i>oh, right, mm</i> [rise-falling]
‘Change of activity’ tokens	Mark move to a new topic	<i>okay, alright</i>

Table 2.3: Gardner’s back-channel function categories, including the different uses of *mm* (2001)

Gardner pays particular attention to *mm*, and how different intonational contours can affect its function as a response token. Most commonly (70%) it appears with a falling contour and he calls this the unmarked, most neutral option, functioning as an acknowledgement token (2001:201). A fall-rising tone turns *mm* into a continuer: this is the typical contour of continuer responses, signalling hearing in the falling tone and encouragement to continue in the rising tone, but remaining relatively neutral in terms of emotional or evaluative content (Gardner 2001:99). The most marked case of *mm* is the rise-falling (or high falling) instance, which

Gardner associates with positive or negative assessments or emotions (2001:235), and considers to be a 'more semantically-neutral' and 'less highly-involved' version of assessment tokens such as *great* or *wow*, for which this contour is typical (2001:187). Using previous work on prosodic cues for involvement (e.g. Tannen 1984; Selting 1994) Gardner found *mm* responses in this category were regularly used in combination with other prosodic features that cue heightened involvement, such as lengthening and increased volume (2001:234). Thus, the rise-falling *mm* can express 'sympathy' or 'affiliation' (Gardner 2001:241,243).

Intonational evidence is used in chapter 3 to justify the separation of the back-channel *mm* into two different response categories, and is extended to treat different uses of *yeah* and *ok* similarly. Ruusuvuori used similar evidence to distinguish between affiliative and non-affiliative minimal responses in her study of the role of emotion in healthcare communication (2007:600). These decisions are further supported by work identifying other prosodic features as indicative of heightened emotional involvement, such as lengthening, loudness and high pitch (e.g. Cruttenden 1986; Tannen 1984).

2.3 Teaching communication and empathy

Much of the societal criticism of health care relates to inadequacies in interpersonal and communication skills rather than medical knowledge or performance (Buckman *et al.* 2011). Successful doctor-patient communication has been shown to have significant positive effects, such as greater patient satisfaction and reduced emotional distress, as well as increased compliance with treatment instruction, thus impacting the medical outcome (Kim *et al.* 2004).

Demonstrating empathy while responding to patient concerns is acknowledged as a significant element of interpersonal communication within the consultation, and one that still needs improvement (e.g. Buckman *et al.* 2011; Finset 2010; Ruusuvuori 2007). In particular, it is said that doctors often miss patients' more subtle expressions of concern, where they use indirectness, prosodic cues or other hints to allude to relevant issues instead of stating them explicitly (Sator *et al.* 2008). The fact that patients frequently present concerns in this way

(Ruusuvuori 2007:604; Suchman *et al.* 1997:678) demonstrates the significance of this issue and the need for improvement in identifying these expressions.

Following this identified need, the teaching of clinical interpersonal skills has been increasingly prominent in medical education (Gask & Usherwood 2002:1567). For example, the 'three function' model for consultations (Bird & Cohen-Cole 1990) is taught widely in medicine and includes many interpersonal strategies within its three functions of gathering data, developing rapport and delivering information (Gask & Usherwood 2002:1567). Some techniques currently taught in this model, and others, to help doctors elicit and respond to patients' concerns in an appropriately empathic manner, will be discussed in section 2.3.1. Studies have followed up on some of these teaching strategies and shown that they can be effective, and therefore that clinical empathy can indeed be taught, despite the assumption that it is intuitive (e.g. Buckman *et al.* 2011). However as discussed below, the existing teaching strategies are not comprehensive and could be improved to allow doctors a greater understanding of why the 'empathic comments' they are taught (e.g. Gask & Usherwood 2002:1568) are indeed empathic, and how they can use this knowledge to create their own such comments.

Section 2.3.1 outlines some of the strategies taught in medical education to improve interpersonal skills and communication, particularly regarding the display of clinical empathy. The following section, 2.3.2, introduces some models used in medical research to analyse empathic communication, before section 2.3.3 discusses developments from a linguistic background and how this thesis aims to extend on the existing work.

2.3.1 Interpersonal skills in medical education

Gask and Usherwood encourage the use of 'active listening' strategies such as open-ended questions, facilitative comments (allowing the patient to express his/her whole narrative, e.g. *go on*, nodding), legitimisation of feelings (e.g. *you do have a lot to deal with*) and supportive comments (e.g. *I want to know how I can help you*) (2002:1568). This text also touches on methods of making patients' underlying or hinted concerns explicit, for example by seeking clarification directly (e.g. *what do you mean when you say you always feel tired*) or prompting

elaboration by repeating the patient's words (e.g. *not well since your mother died...*), but these strategies rely on doctors being able to identify the hinted concerns in the first place.

Another popular training text is the 'Four Habits for Clinical Success' (FHCS) model of empathic communication, a system developed to target inadequacies in interpersonal skills (Frankel & Stein 1999). In its 'Demonstrate Empathy' section, this model encourages physicians to probe for patient concerns by suggesting 'likely emotions' (e.g. *that sounds upsetting*) or asking about anticipated impacts on other areas of the patient's life (e.g. *how has the illness affected your work?*) (Frankel & Stein 1999). Physicians are advised to 'look for opportunities to use brief empathic comments or gestures', and 'use a pause, touch, or a facial expression' (Frankel & Stein 1999), but few guidelines about the nature of these 'empathic comments' are given. Greater understanding might be achieved by establishing a linguistic framework that uses a defined systematic model (such as the APPRAISAL system) to describe the components of a successful empathic exchange. This is an idea taken up by Pounds (2011; see 2.3.3) and further developed in this thesis.

Doctors can also be taught that back-channels can 'facilitate communication' and 'create rapport' when used successfully: for example, the 'Doctors Speak Up' website, which aims to develop communication skills (Woodward-Kron *et al.* 2010). It describes how falling-tone back-channels indicate recognition that the patient has finished speaking and the desire to take up the next turn, while fall-rising tones demonstrate interest and encourage the patient to continue (Woodward-Kron *et al.* 2010). If this information could be combined with knowledge of how back-channel responses can show emotional involvement (e.g. Gardner 2001, Lambertz 2011), doctors could be given more explicit details about the ways in which they can use back-channelling to build rapport.

Whilst all these and other existing strategies do provide good examples and have already been shown to be effective (Buckman *et al.* 2011), they do not consistently take their analysis down to the level of the actual language used to express these understandings (Cegala 2002:1013-1014). Thus they miss the opportunity to give a wider overview of language's potential for empathic expression. Some guidelines go without examples at all and so remain too vague to specify what exactly, for example, an 'empathic gesture' is (Frankel & Stein 1999). Often when

examples are provided, the guidelines do not identify how language has been used to achieve successful empathic communication (e.g. *this is clearly worrying you*: Gask & Usherwood 2002:1568). This thesis intends to give a closer analysis of the language of clinical empathy, to identify the linguistic features and thus help increase understanding of what constitutes successful empathic interaction.

2.3.2 Medical models of empathy

The medical research community has put forward several models of empathic communication which have been used to assess healthcare workers' abilities to respond to patients' concerns (e.g. RIAS: see Roter & Larson 2001; ECCS: Bylund 2001; Levinson *et al.* 2000; FHCS: Frankel & Stein 1999; Clay 1984). Because they are designed for assessing current practices, not specifically for outlining how empathy *can* be communicated (that is, they are aimed at adjudicating, not educating), such models are limited to aspects of empathic communication that are readily identified and coded. As will be further explained in this section, coding systems designed to assess physicians' communication are restricted to explicit patient cues and thus many ignore the significant area of indirect cues. They are also more concerned with doctors' ability to acknowledge these expressions with some response than with analysing the nature of different responses. What follows is an overview of some of the existing medical models of empathy and a discussion of how they can be developed to shift focus to education of empathic communication.

Suchman *et al.* used Branch and Malik's (1993) research to propose a base framework for models of empathic communication in clinical settings (1997). In this paper, they introduced the term 'empathic opportunity' to describe 'a direct and explicit description of an emotion by a patient', which provides an opportunity for the doctor to give an 'empathic response' (Suchman *et al.* 1997:679). In her Empathic Communication Coding Scheme (ECCS) for measuring physicians' demonstration of empathy, Bylund extends the definition to a 'direct and explicit statement of an emotional feeling, a progress or a challenge', claiming that restricting it to emotion meant 'other, direct opportunities for empathic communication were being missed' (2001:5). Bylund acknowledges that this definition is 'certainly not all-inclusive' (2001:7), and

her justification for keeping the term limited to explicit statements is that if doctors do not respond to these sorts of expressions, 'it is unlikely they would respond to more subtle empathic opportunities' (2001:6).

Levinson *et al.* did extend their work to include 'potential empathic opportunities', finding most implied feelings to be embedded in discussion about the medical condition, loss, stress or life changes (2000:1024). The line between what does and does not represent an 'emotional patient-initiated clue' is difficult to define, and this model relies solely on interpretation of the ideational content. This can be problematic, for instance in deciding when statements of pain become emotional clues versus the discussion of symptoms expected in the field of medical discourse (see Halliday 1998 for further discussion of the complexity of pain in both grammar and overall human experience). Levinson *et al.* found that doctors 'pass up' empathic opportunities in the majority of cases when they are presented with one by the patient, either explicitly or implicitly (2000:1026). However it is arguable that this assessment is skewed by their model of responses: in classifying the doctors' responses, they only include explicit statements of understanding or support, and all back-channel type responses are classed as missed opportunities, regardless of intonation, along with direct rejection, denial and inappropriate humour (Levinson 2000:1023). This thesis will take a different perspective on back-channels and other ways in which doctors can demonstrate implicitly some level of understanding. Guided by the work of, for example, Gardner (2001) and Cruttenden (1986), it analyses some back-channels as emotionally engaged and functioning as less but still somewhat involved versions of more explicit responses. That is, although they do not show the same level of empathy as a direct statement, they are still offering some emotional acknowledgement and should not be categorised with missed opportunities.

Sandvik *et al.* give some examples of how linguistic theory could improve the current understanding of how empathy is realised in language in their critique of the RIAS (2002). From a conversation analysis perspective, they criticise RIAS's narrow definition of empathy: it does not include indirect or gradual expressions of empathy and, as in many other models, the examples given are limited to straightforward paraphrasing of the patient's feelings such as *you must be worried* (2002:240). They also challenge the model's tendency to associate syntactic form with pragmatic function, for instance in defining *this is distressing for you* as a socio-

emotional exchange ('Empathy') but *what bothers you the most?* as a task-oriented question-answer exchange (relating to psycho-social feelings but not classed as 'Empathy') (2002:240). Sandvik *et al.* claim empathy should not be dependent on form and that in declaring so the RIAS 'neglects the insight brought about by modern linguistic theory' (2002:240). This thesis will consider these issues when proposing some linguistic characteristics of empathic communication.

Unlike previous research such as Branch and Malik (1993), Bylund (2001), and Bylund & Makoul (2002) which aimed to develop and implement models for assessing the empathic responses physicians already make, this thesis aims to explore the wider spectrum of options doctors have in identifying and responding to patients' concerns. It must therefore include those that are presented implicitly. Other work has considered these 'potential empathic opportunities' (Suchman *et al.* 1997) or 'clues', notably in the work of Levinson *et al.* (2000), but still found them difficult to identify and categorise (Bylund 2001:7). However, their frequency makes them an important component of any overall understanding of empathy (e.g. see Ruusuvuori 2007:604; Suchman *et al.* 1997:679). Hence here the term 'empathic opportunity' (described in section 3.1) and the analysis in this thesis will encompass both explicit and implicit expressions. It will also consider how acknowledgement or support may too be presented implicitly in doctors' expressions of understanding when responding to patients' empathic opportunities.

2.3.3 Modelling medical empathy through APPRAISAL

Despite the prominence of the issue and the increasing use and success of communication training, research shows there is still much room to develop empathy in healthcare (e.g. Buckman *et al.* 2010; Slade *et al.* 2008.). Currently, as shown above, medical education usually focuses on identifying select phrases or structures that help form interpersonal bonds with patients, e.g. *I understand how important it is for you to get back to work* (Segal 1995) or open-ended questions instead of polar (*yes/no*) interrogatives (Gask & Usherwood 2002:1568).

This tokenistic approach certainly does provide useful information and has indeed been shown to be very successful, however it is not comprehensive: medical education does not have a

framework for teaching the full potential of language to express empathy. Without an understanding of the characteristics that make these expressions empathic, doctors are restricted in their understanding of the linguistic structures available for successful interpersonal communication. This limits doctors' abilities to identify patients' indications of concern and to create their own empathic expressions.

A linguistic model which characterises the finer details of empathic communication could help teach physicians how empathic opportunities and responses are constructed. Understanding the linguistic features to look for and use would help doctors develop their interpersonal skills (Pounds 2011; Sandvik *et al.* 2002). In a recent paper, Pounds proposed a model of medical 'empathy as appraisal' (2011). This model aims to provide a categorised overview of the language resources available for empathic expression, enabling doctors not only to identify key phrases that associate with rapport, but to understand the linguistic structures behind the communicative expression of empathy. Pounds' theory identifies three components of doctors' empathic communication: interpreting patients' feelings (AFFECT) and views (JUDGEMENT and APPRECIATION), eliciting them and responding to them. Pounds proposes to define patients' empathic expressions as those containing ATTITUDE, either inscribed or invoked (2011:152-153). Interestingly, this model is restricted to negative attitude, only including positive attitude in the form of positive self-judgement (2011:152). However bonding over positive expressions can also be significant factor of rapport-building and so this thesis will consider both positive and negative attitudinal expressions by the patient.

Regarding patients' empathic expressions, Pounds acknowledges doctors must be aware of both explicit and implicit cues; if patient feelings/views are instead elicited by the doctor, it can also be done in either a direct or indirect manner (2011). In responding to these expressions, doctors can 'understand', 'share' or 'accept' the feelings/views presented by the patient. These response options are summarised in Figure 2.2:

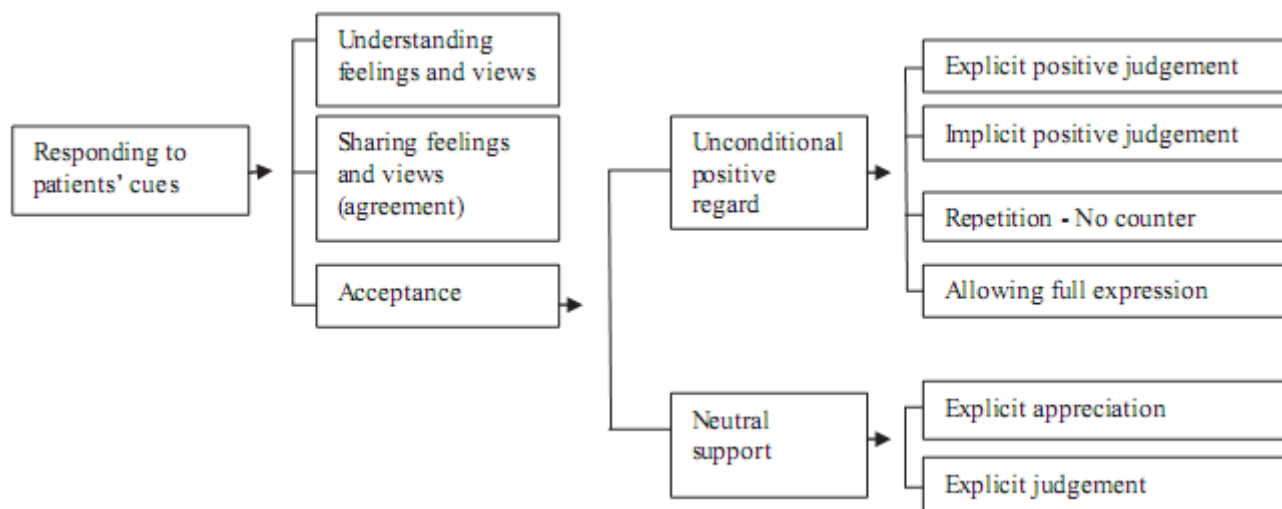


Fig 2.2: Pounds' model of responses to patient cues (2011:157)

In an understanding response, a doctor directly states understanding or acknowledgement of the patient's expression, for example *I understand* or *it seems* with a reference to the patient's affective state or view (Pounds 2011). Sharing involves repetition of the patient's inscribed attitude (or related attitude) or interjections (e.g. *oh no!*) to demonstrate agreement (2011:155). The third option, acceptance, covers other responses that do not directly validate the patient's proposed attitude but offer support in one of the following ways: positive judgement of the patient, repeating his/her words to demonstrate hearing, allowing him/her to express these views uninterrupted, or confirming the normality of his/her ideas or behaviour (2011:156-157).

A model grounded in the APPRAISAL system in this way could aid in educating medical professionals about the ways in which language can be used to communicate interpersonally. Rather than relying on key phrases or syntactic structures it can provide an overview of a greater spectrum of linguistic capabilities for empathic expression. As yet, Pounds' work is only theoretical and has not been implemented and assessed for its descriptive accuracy of the components of empathic expression, or for its usefulness as a model in medical education. It does however make an interesting link between empathic communication and the resources of the APPRAISAL system that encourages further research and, in particular, empirical study. This thesis aims to build on this idea in relation to an SFL theory of bonding, applying these concepts

to analyse doctor-patient interaction and provide linguistic criteria to help describe how doctors can communicate empathy effectively.

2.4 Data and methodology

This thesis uses audio recordings of eight consultations from a specialist gastrointestinal clinic in a NSW hospital. The doctor studied is a very well regarded and experienced surgeon who is involved in much medical teaching and known for his good communication skills, both by other medical staff and by his patients. This fact has been established in highly positive feedback from patients as well as medical and non-medical colleagues, and he has been used as a model communicator in previous studies (unreferenced here to preserve anonymity). The consultations range from 6 to 34 minutes in duration, making a total of two hours of audio data. They have been transcribed and, as they were recorded in person in the consulting room, the audio and transcription data are supported by notes taken during the data collection. In this data, approximately 350 empathic exchanges (empathic opportunity (defined in section 3.1) + doctor's response) were identified and examined, and this analysis forms the basis of the proposed model. The random patient sample includes variation in age, gender, medical history and familiarity with the doctor, and other family members are also present in three of the consultations.

As is often the case with a specialist consultation, the doctor is familiar with most of his patients and very familiar with several, having treated them regularly for many years. For this reason, the structure of the consultation is different to those that have been more widely studied: the general practitioner (e.g. Tebble 1999) and emergency department consultations (e.g. Slade *et al.* 2008). These types of consults have a more consistent generic structure with fairly clearly defined stages and phases (see e.g. Tebble 1999 and Slade *et al.* 2008), however the specialist consults used in this research do not fit these models. As the patient and the condition are usually well known to the doctor, there is little or no introduction or medical history taking and the consult quickly moves to discussion of the current problem.

This thesis focuses qualitatively on an expert communicator of clinical empathy to model the language strategies he uses to build rapport with his patients. As it analyses only one expert communicator it is not intended to be a complete overview of language's potential to construe empathy. It provides an in-depth, systematic analysis of the linguistic characteristics used in this example of effective communication, which can be used as a model of clinical empathy. The ultimate aim is to be in a position to help doctors understand how they can use language to show empathy with their patients and identify when patients are expressing a potential concern.

Chapter 3: Responding to empathic opportunities

This thesis is concerned with the characteristics of successful exchanges of clinical empathy in the specialist consultation context. Chapter 3 considers instances where the patient offers some potential empathic expression over which the participants may bond: an ‘empathic opportunity’ (to use the term coined by Suchman *et al.* 1997, extended by Bylund 2001, and further extended in this thesis: see section 2.3.2), and the various ways in which these proposed bonds may be negotiated. It explores the types of expressions over which participants choose to bond, as well as those that are deemed inappropriate and thus deferred or rejected. A model is proposed to display the different options doctors have in responding to these expressions, presenting a linguistic ranking of responses according to the levels of empathy they express. The research aims to categorise these linguistically, in the hope that greater understanding of the language criteria will help health professionals understand how to use this knowledge to improve interpersonal communication – allowing them to be more inventive with the language of empathy and less reliant on the tokenistic approach of medical education (see section 2.3).

This chapter presents a graded scale of responses, ranging from high to low commitment, displaying how doctors can control the degree of empathy they display. Only doctor responses to empathic opportunities expressed by the patient or patient’s family will be analysed in this chapter. The thesis is not concerned with bonds initially proposed by the doctor as these have different implications for interpersonal meaning and rapport, and the focus for improvement in this field is responding to patient concerns (e.g. Buckman *et al.* 2011; Sator *et al.* 2008; Ruusuvaori 2007; Suchman *et al.* 1997).

There are also the options which allow a doctor, patient or family member not to respond to the proposed bond: to defer or reject it. Sometimes in these instances the patient/kin defers the bond before the doctor gives a response. These are included in this analysis as they identify values the participants choose not to commune around, and thus form an important part of the analysis of affiliation.

3.1 Patient/kin expressions of empathy

Before turning to the ways in which doctors can respond to empathic expressions, it is necessary to specify the criteria for identifying these expressions in the first place. In previous studies, researchers have looked for direct statements of emotion or 'challenge' (e.g. Bylund 2001; Suchman et al. 1997) but have acknowledged the limitations of excluding indirect 'potential empathic opportunities' or 'hints', as well as the existing ambiguities around defining such 'clues' (Bylund 2001:7; also see section 2.3.2).

For example, Bylund and Makoul define an empathic opportunity as a 'clear and direct statement of emotion, progress or challenge by the patient', where progress is a development improving quality of life, and a challenge negatively affects quality of life (2002:209). They reason that doctors would be unlikely to respond to indirect expressions of emotion if they do not respond to these direct ones (2002:209). However it is the case that much of patients' emotional expression is indeed indirect (e.g. Ruusuvuori 2007:604; Suchman *et al.* 1997:679), and therefore an integral part of the process of negotiating bonds. Thus indirect expression does need to be considered in any model designed to improve doctors' ability to identify and express empathic understanding.

Pounds' suggestion that empathy be modelled through APPRAISAL led to her criteria of patients conveying ATTITUDE (AFFECT, JUDGEMENT OR APPRECIATION), which helps in identifying instances where the attitude is inscribed directly, as it provides clear linguistic criteria for direct expression of emotion or opinion. However this faces the same ambiguities in identifying instances of invoked attitude, for example when descriptions of pain invoke affect rather than being expected ideational content in a medical field, and in identifying the emotion in 'negative experiences' (e.g. *I still had not received the letter from the hospital* (2011:151)). Also, while Pounds' model only considers patients' negative attitudinal expressions (2011), positive expressions can also be bonded over and indeed this is a significant element of the rapport established in communication (see Martin & Stenglin 2007; Knight 2010). Thus this thesis considers both positive and negative attitudinal expressions by the patient.

In defining these expressions in this thesis, the criteria of the APPRAISAL system are used to include all examples containing inscribed APPRAISAL (direct expressions of emotion or opinion), following Pounds' model (2011), as well as some targeted invoked attitudes. Expressions conveying invoked emotion are more difficult to define than those invoking JUDGEMENT or APPRECIATION. This relates to how the targets of JUDGEMENT (people/behaviour) and APPRECIATION (things: albeit both concrete and abstract) are consistently categorised (see Martin & White 2005:59) and hence more readily identifiable than the triggers of AFFECT. In picking up invoked AFFECT, this thesis considers graded pain as well as descriptions of disruption, which convey a sense of distress and 'afford' AFFECT (see Martin 1996 for analysis of the evaluative effects of field disruption). That is, not all statements of pain are considered empathic opportunities, only those including GRADUATION (e.g. 'a fair bit of pain') or other attitudinal lexis (e.g. 'crippling pain') to 'flag' AFFECT (categories of invoked AFFECT from Martin & White 2005).

3.2 Graded model of doctors' empathic responses

Below is a tabulated representation of the framework proposed in this thesis for modelling doctors' responses to patients' empathic expressions. It categorises the options available into six classes ranked according to the degree of empathy conveyed, giving examples from the consultation data. Bonding is only considered successful if a level 4-6 response is given, as these are the instances where the doctor aligns with the ideation+attitude evaluative coupling presented. Bond acceptance is split into these three levels of empathy according to how explicitly the doctor confirms the coupling. Options 1-3 offer varying levels of acknowledgement of the value proposed but none constitute communing. There are also the options not to respond, to defer the bond through laughter (which could be done by any of the participants) or to reject the bond.

Rank	Response type	Description	Linguistic criteria	Example
6	Share	Dr explicitly shares the patient's emotion or describes having a similar experience	Same AFFECT inscribed (or invoked in description of similar experience)	<i>I mean I've had the bowel prep for a colonoscopy and I surprised myself</i>
5	Validate	Dr conveys understanding of the patient's expression	Inscribed related attitude, verb of understanding, or exclamation	<i>I understand; what a nuisance; wow</i>
4	Accord	Dr implicitly conveys agreement without inscribing attitude	'Agreement' back-channel – equating to elided agreement	<i>yeah; mm (with high fall or rise-falling intonation contour)</i>
3	Support	Dr acknowledges the patient's expression by validating the patient or his/her behaviour, not the attitude that has actually been expressed	Positive judgement of patient or patient's behaviour (includes normalisation)	<i>everybody says that; [you're] so strong with it; you're a very tough guy</i>
2	Acknowledge	Dr acknowledges the patient's expression without direct reference to the evaluative content	Back-channel with attitudinal content, inc. 'idea connector' back-channel ('right')	<i>good; right; ok (if prosodically marked – greater stress, volume, duration, rise-fall)</i>
1	Listen	Dr acknowledges that the patient has spoken rather than the context expressed	'Continuer', 'comprehension' (=acknowledgement) and 'change of activity' back-channels	<i>mmhm; uh huh; mm (with short, falling intonation contour); ok (unless as above); alright</i>
	No response	Dr does not respond to patient's expression	Immediate topic change; silence	
	Defer	Empathic expression is laughed off, deferring the proposed bond: Knight's 'laughing affiliation' (2010)	Laughter (from any participants, not necessarily the doctor)	
	Reject	Dr rejects or denies patient's expression	Explicit disagreement with expression	<i>I'm not sure...if it's really true</i>

Table 3.1: Graded model of doctor responses. Back-channel definitions from Gardner (2001)

3.2.1 LISTEN

The LISTEN response is one of basic acknowledgement that displays to the speaker that they are being listened to without acknowledging any of the particular content expressed. This response pertains more to the 'regulatory' level of the discourse (the 'discourse of social order': see Bernstein 1990:183) where it acknowledges that the speaker has spoken and functions on a more abstract level to control the textual flow of the consultation (e.g. through turn-taking). LISTEN includes the back-channel category of 'continuers', which show that the hearer is listening and encourage the speaker to continue – such as *mmhm*, *uh huh* and, when it has a short, falling intonation contour, *mm* (Gardner 2001). Also included are 'change of activity' back-channels such as *ok* and *alright*, which function to acknowledge the speaker's utterance and then move the conversation to a new topic (or subtopic) (Gardner 2001).

In the example below, a patient discloses his full trust in the doctor's final decision:

- P: if your decision is you wanna do so and so
because you believe that's right
- D: mmhm (1)
- P: then I'm good

The doctor gives just a LISTEN response of 'mmhm', indicating to the patient that he has heard his utterance but not directly acknowledging his expression of trust in the doctor's decision. The doctor also, in doing so, does not confirm to the patient that this decision is indeed what he believes is 'right', which would have demonstrated greater connection of the attitudinal content of the patient's utterance.

Other studies of doctor-patient interpersonal communication have identified this type of response as seemingly 'automated' or 'scripted' and often with the doctor turned away from the patient and involved in another task (e.g. Bylund & Makoul 2002:215). This reveals the significance of paralinguistic communicative features in analysing interpersonal communication: a short, low falling *mm* with eye contact conveys a greater degree of empathy than the same response with the doctor's body oriented away from the patient (Bylund & Makoul 2002:210-

211). This is however a further distinction that can be made with video recorded footage and in this analysis, which is limited to audio recordings, the LISTEN category responses have not been subclassified by this distinction.

A distinction that can be made however is that of intonation, especially regarding the *ok* response which is somewhat borderline between categories 1 and 2. Gardner explains how *ok* is more engaged than *alright* because it is more connected to the content of the previous utterance, as shown in its function as a topic-changing back-channel where *ok* is used to move between smaller stages of the discourse than *alright* (which tends to introduce larger topic shifts (2001:57)). *Ok* also has some attitudinal content, which suggests it can show greater engagement than typical LISTEN responses. This has been recognised in medical education, where some students have been told not to use *ok* as an active listening back-channel as it is seen to equate to *good* and reflect a positive assessment (Beach 1995). This would be justification for considering *ok* an ACKNOWLEDGE response. However as Beach explains this is not the case and *ok* actually functions to move to the next question or set of questions in the consultation (1995; similar findings in Slade *et al.* 2008). For this reason, *ok* has been kept in the LISTEN category except when it is pronounced with greater volume, duration and stress and with rise-falling or rise-fall-rising intonation. In this case it is seen to be more engaged (Gardner 2001:19): more expressive of its attitudinal content and thus considered an, ACKNOWLEDGE response.

The following example demonstrates the use of *ok* to change topic. The doctor has asked the patient for a summary of her prior appointment with another doctor, and this extract comes from the end of her recount.

D: did you get the impression that he was **concerned** about your bottom?

or

P: um

D: I think

P: I don't think he was **so much concerned** he-

in taking the history I mentioned

that I **occasionally** particularly in the mornings get **a bit** of RIF pain

D: ok (1)

P: and um **funnily** enough over the last few days I've had **a little bit** of crampy **sort of** pain

Here the doctor's 'ok' response is low in volume, pitch movement and overall pitch: by Cruttenden's (1986) criteria low in emotional engagement, so functioning to acknowledge the end of the patient's recount and move into the question set (as in Beach 1995). Indeed, after this response the patient does move to start describing her current symptoms. These acoustic properties can be seen in the spectrogram in Figure 3.1 below, compared with the following Figure 3.1 of a marked, ACKNOWLEDGE 'ok' response (images obtained from audio data using PRAAT software – Boersma & Weenink 2011).

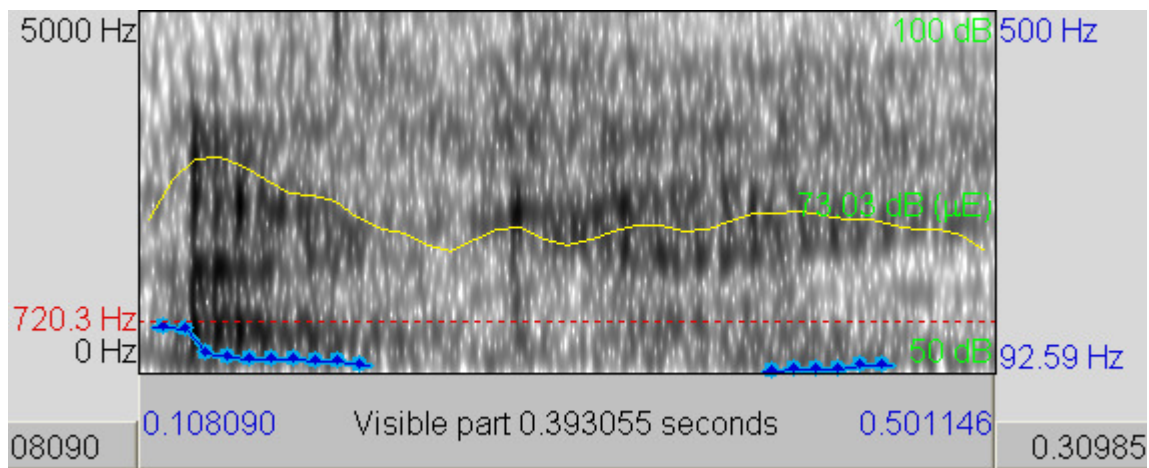


Fig 3.1: spectrogram showing unmarked case of 'ok': compared with Fig 3.2 below, lower volume (intensity: yellow/green), pitch movement and overall pitch (frequency: blue)

The second example (Figure 3.2) is the response the doctor gives when, earlier in this consultation, the patient begins to introduce the reason for her visit by saying she recently went to see another specialist about her current symptoms. This 'ok' response is marked for involvement and functions to acknowledge her words and facilitate further expression, rather than to change the topic.

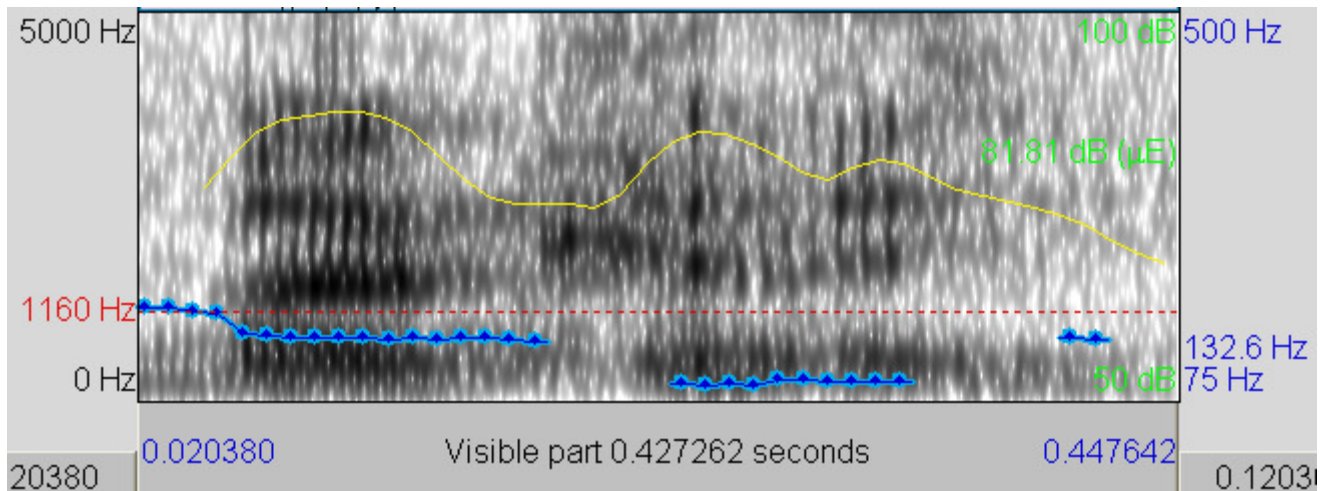


Fig 3.2: spectrogram showing unmarked case of 'ok': compared with Fig 3.1 above, greater volume (intensity: yellow/green), pitch movement and overall pitch (frequency: blue)

3.2.2 ACKNOWLEDGE

Next is ACKNOWLEDGE, where the doctor acknowledges the evaluative content of the patient's expression without directly referring to it. It is only slightly more empathic than LISTEN, and is characterised by back-channels that contain attitudinal content and thus are more engaged with the previous expression. These include responses such as *good* and *right* (see a further below for more discussion on *right*). Also included are emotionally marked cases of *ok*, such as the one introduced in section 3.2.1 to contrast the unmarked LISTEN case.

Below is an extract from a follow-up consultation with a patient the doctor has been treating for many years. The patient tells the doctor that he is not too worried about his wound, and to do so inscribes negated negative AFFECT with raised FORCE.

- P: no that's **not bothering** me **a great deal** **at all**
 in fact I'm **not**
- D: **good** (2)
- P: **worried** about it

The doctor's response 'good' is more engaged than a LISTEN response, as it demonstrates recognition of the attitudinal content of the patient's expression. In saying 'good' the doctor is appreciating the fact that the wound is not bothering the patient. While they surpass the LISTEN responses in recognising some evaluative content in the previous utterance, these responses are still somewhat regulatory in nature. They function more to acknowledge that the speaker has spoken and that their meaning has been understood than to provide support or validation of the evaluative content of the expression. If the doctor had followed up his response with a confirming statement such as *good, it isn't worrying you*, this would show a greater level of empathy with the patient's expression by legitimising his concern and actions. ACKNOWLEDGE demonstrates recognition of the patient's view, but does not offer further support or validation of it, indicating an acceptance but lack of agreement.

Right is a particularly interesting case as a back-channel. Gardner explains how in British and Australian English it usually functions as an 'idea connector', displaying understanding of the connection between two or more ideas that have been expressed and thus showing direct recognition of the content being expressed (2001:47). However in American English *right* tends to have more of an evaluative function, indicating agreement with the previous utterance (as in, *yes, that's right*) (Gardner 2004:4). The American case might support moving *right* further up the table of responses to include it with the validating responses since it is said to convey agreement, however since the data for this study is in Australian English, *right* has been left in ACKNOWLEDGE. It remains to be tested, though, as *right* was never used as a response in the data analysed for this study. This also raises the issue of negotiating empathy in cross-cultural communication, discussed further in chapter 5.

3.2.3 SUPPORT

The SUPPORT response is an intermediate stage between acknowledging and validating: the doctor does convey that the patient's views are legitimate but does so by validating the patient or the patient's behaviour rather than the attitude presented. This allows the doctor to support the patient even when the doctor will not or cannot bond over the value itself. In the following

example, the patient downplays the extent of his current symptoms by explaining how he has suffered worse things previously.

P: I had worse than that

D: you're a very tough guy (3)

In responding to this expression, the doctor does not confirm the patient's statement that he has suffered 'worse' things, but does offer support by giving positive judgement of the patient ('very tough'). This suggests to the patient his expression is valid, without validating its content.

The next extract gives an example of the doctor using normalisation to legitimise a patient's implicit emotion without directly confirming the negative self-judgement through which the affect is invoked. This patient, well known to the doctor, claims to have 'lost [her] dignity' regarding the embarrassment of physical examinations.

P: oh no that's fine with the curtains xxx

I lost my dignity with this years ago

[laughs]

D: everybody says that (3)

I'm not sure if they if it's really true

The doctor responds to this expression by telling her that 'everybody says that' – thus supporting her by stating that her feelings of discomfort or loss of dignity are normal. This acknowledges the patient's expression of negative self-judgement, but instead of communing around it, defers to an implicated bond around the negative feelings behind it. Sharing the patient's negative valuing of herself would endanger their relationship, whereas the implicated bond acknowledges the concern behind it, and thus is more appropriate for communing.

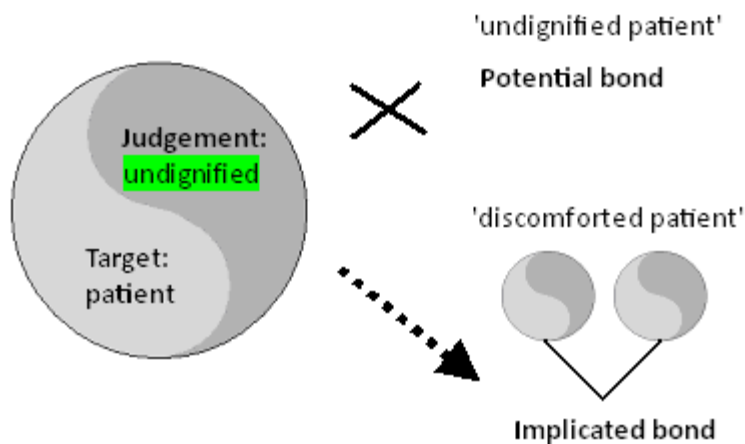


Fig 3.3: the patient's proposed coupling of undignified + herself construes a potential bond, but the SUPPORT response redirects the affiliation to an implicated bond of the patient's discomfort being normal

Bylund and Makoul conflate these types of responses with other 'confirmation' responses (which otherwise essentially map to response option 5: VALIDATE in this model), stating that this reaction also provides confirmation, legitimising the patient's emotion/experience (2002:215). However these responses are considered significantly different to warrant separating them into different response categories – SUPPORT involves a decision to withhold personal opinion regarding the attitudinal content expressed, but still offer support for the patient by legitimising his/her perspective (Pounds (2011) also separates this option). This conveys less empathy than VALIDATE or ACCORD, as these do engage with the attitudinal content expressed and offer affirmation. They accept the proposed bond as something to commune around, whereas the SUPPORT response does not: if there is another potential bond presented through invoked affect that the doctor decides is more appropriate for communing, he may defer to this alternative implicated bond (as seen in the previous example). The SUPPORT option therefore involves a lesser amount of empathy being displayed by the doctor and has been separated from the following categories.

3.2.4 ACCORD

Above this, the responses move to validation of the patient's empathic expressions, or focal engagement with the 'empathic opportunity' (terminology from Suchman *et al.* 1997), and through this, 'communing affiliation' (Knight 2010). In giving an ACCORD response, the doctor implicitly confirms the patient's evaluative expression. These responses include the most emotionally engaged 'agreement' back-channel utterance *yeah*, as well as slightly weaker *mm*, when used with a high falling or rise-falling intonation contour (see Gardner 2001:99). These responses demonstrate not only acknowledgement but also understanding and validation of the patient's feelings or views, thus displaying a higher degree of clinical empathy than the previous options.

Below is the extract discussed in section 3.2.1 with regard to the LISTEN response which builds to more empathic responses throughout the exchange. The patient describes troubles faced when trying to return to work with an embarrassing bowel condition:

- P: 'cause some of the girls are being less than supportive
- D: mm [high fall, longer] (4)
- P: and very juvenile
- D: mm [low fall, shorter] (1)
- P: um and also there's a majority of the work I'm not physically
- D: yes (4)
- P: sort of able to do
- D: yeah (4)
- P: so I've been cleaning the kitchen and doing really sort of menial
- D: ok (2)
- P: stuff
- which has been doing my head in
- D: yeah (4)
- P: so she's just said let's take a another break from it
- and um get you sort of back into a good head space
- D: mm [high fall, longer] (4)

The initial 'mm' response has a high falling intonation contour and long duration, marking it for emotional involvement (see Cruttenden 1986) and thus considered an ACCORD response. This demonstrates to the patient that the doctor recognises the emotional distress behind her description of 'less than supportive' colleagues and is conveying his acceptance of her perspective. He then follows with a LISTEN response (unmarked 'mm'), before returning to ACCORD responses 'yes' and 'yeah' to acknowledge and validate her expressions of frustration at being unable to do her regular tasks (see chapter 4 for more discussion of how empathy levels develop within an exchange complex). This conversation builds a representation of the patient's emotional distress while coping with problems at work: Figure 3.4 illustrates the bond created.

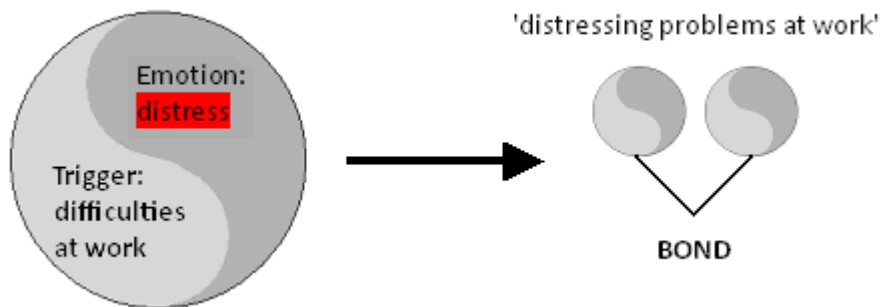


Fig 3.4: coupling of distress + difficulties at work construing a bond, which is communed around once accepted by the doctor with ACCORD responses

To demonstrate the acoustic properties behind the distinction of marked and unmarked *mm*, below are spectrogram images, with pitch contour marked, of the first and second 'mm's in the above extract (lines 2 and 4) (images obtained using PRAAT: Boersma & Weenink 2011). The first starts at a higher pitch, approximately double that of the second, and has a longer overall duration. These are markers of emotional involvement (Gardner 2001; Cruttenden 1986) and thus this response is considered to be engaged with the emotional content of the previous utterance, and a level 4 ACCORD response.

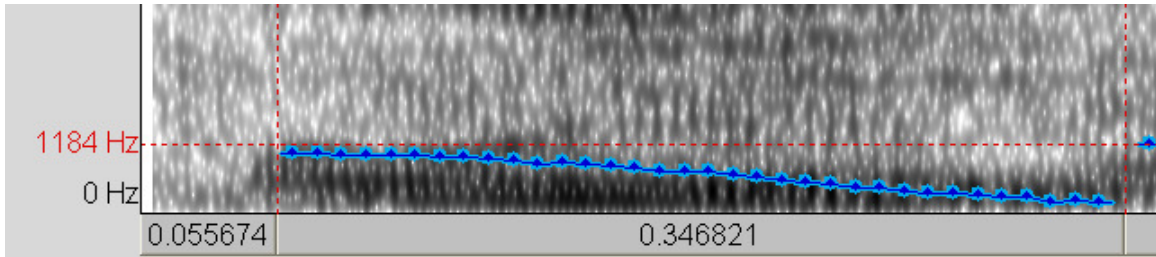


Fig 3.5: spectrogram with pitch contour for marked 'mm' (after 'less than supportive')

The second 'mm' starts at a lower pitch and falls over a shorter duration of time. This is the typical, unmarked case and the most common use of *mm* in everyday conversation (Gardner 2001:201:187). Gardner considers this *mm* an 'acknowledgement' back-channel (2002:187) and as a response functioning mostly to signal to the speaker that the listener is hearing them. For this model it is classed as a LISTEN response.

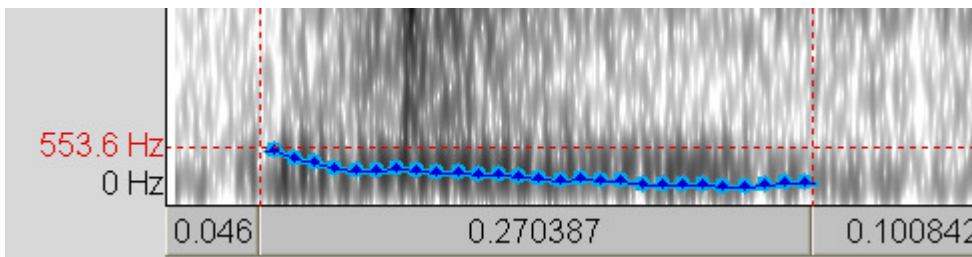


Fig 3.6: spectrogram with pitch contour for unmarked 'mm' (after 'very juvenile')

3.2.5 VALIDATE

The second highest empathic response option is VALIDATE, whereby the doctor directly legitimises the patient's expression, using a verb of understanding or inscribed attitude that reflects that which the patient expressed. This response confirms to the patient that his/her expression is valid and the doctor understands why the he/she is feeling this way, without going beyond this level of understanding to share the sentiment expressed. It displays a higher degree of empathy than the previous option (ACCORD) through the explicit use of attitudinal lexis (direct inscription of attitude).

Below is an example where the doctor directly inscribes attitude in displaying his understanding of the patient's situation. In this extract, the mother of the young male patient describes the nuisance that reapplying to the navy is going to be for the patient, since his medical condition prevented him from following through his first, successful application.

M: I mean he has to apply **all over again** then

D: yep (2)

M: cause they

D: =no it'll be a **real drag** (5)

M: =xxx hold it every 12 months

The doctor identifies the frustration being expressed implicitly by the mother and puts it into words himself in his response ('a real drag') to show his understanding and sympathy to the patient and his family. This illustrates how the VALIDATE response goes beyond the ACKNOWLEDGE and ACCORD levels to rally around the bond proposed in the attitudinal expression (see Figure 3.7).

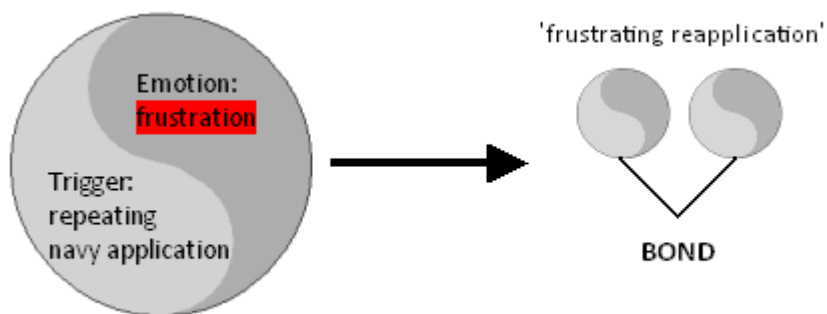


Fig 3.7: coupling of frustration + navy reapplication construing a bond, which is communed around through the doctor's VALIDATE response

3.2.6 SHARE

The highest level of empathy is conveyed by the SHARE response. This is when the doctor explicitly states that he/she shares the patient's experience and in doing so brings his/her own

emotions into the negotiation. In the language, this is represented by inscription of the same emotion (AFFECT), or invoked emotion in a description of having the same experience. In the following example, the doctor asks the patient about bowel control issues during the colonoscopy preparation, and decides to disclose his own experience and explain how he reacted:

- D: Oh look before I do
any trouble
you know when you had the bowel prep and so on
any trouble controlling the bowels at all?
- P: Um well you've got to be quick
[smiles]
- D: you do have to be quick
I mean I've had the bowel prep for a colonoscopy
- P: Eh
- D: and I surprised myself
- P: Eh

The doctor's description of having the same experience plus the inscription of his emotional response convey a high degree of empathy to the patient, showing that the doctor not only understands what he is going through but can share the experience as he has been through the same.

3.3 Non-empathic responses

The remaining options are those to ignore, defer or reject the proposed bond. This section focuses on deferral, analysing how laughter can be used to defer potential bonds and defer to implicated bonds instead, creating a different kind of affiliation to direct communing (see Knight 2010). Of course, the doctor also has the options to ignore or deny the empathic opportunity offered by the patient, such as by making no response and moving onto a new topic or by making a statement that 'disconfirms' what the patient said (Bylund & Makoul 2002:215). Since

this is not regarded as a successful move in interpersonal medical communications and this thesis is focused on describing the qualities of good empathic communication, these response options will not be discussed in detail.

3.3.1 DEFER (laughing affiliation)

A further response strategy that this thesis examines is the deferral of the empathic opportunity through laughter. This is a different sort of reaction that can follow an empathic opportunity: the doctor neither accepts nor rejects the bond, instead it is 'laughed off' (see Knight 2010) by one or more of the participants. As with the exchanges analysed above, this section considers empathic opportunities presented by the patient, but response analysis in this section expands to consider not only the doctor's responses to these empathic expressions but also to include the behaviour of the patient or other present family members in laughing off the bond before the doctor responds. This expansion is necessary because in these instances it is mostly the patient or kin who laughs off the proposed bond, seemingly in recognition of the fact that it is not something around which it would be desirable or appropriate to commune.

This concept of bond deferral through laughter was initially described in Knight's study of the function of laughter in casual conversations (2010). Knight suggests that laughter 'signals that there is something around which the participants *cannot* straightforwardly bond', indicating that the proposed value is 'laughed off' as one around which they cannot currently commune (2010:152). However this response also does not serve as a rejection of the proposed bond, but rather a sort of postponement, indicating that the value proposed is one over which the participants are currently unable to bond but perhaps could if the coupling of ideational and evaluative meaning were presented in a different situation. Knight's 'Happy Fatness' bond example introduced in section 2.1.3 illustrates this situation, where a group of young females laugh off positive appreciation of eating a lot, to instead rally around the 'implicated bond of being thin and beautiful' (2010:227).

In the medical consultations analysed, a number of proposed bonds are deferred through laughter by one or more participants. This laughter response functions as an indication that

values are being proposed that cannot be shared by all participants, but are not directly rejected either. Section 4.1.7 will provide further analysis of the sorts of attitudes that are not bonded over in this context and why they might lead to bond deferral in anticipation of rejection.

As an example, deferral can occur if the patient tries to trivialise the medical issue, since it would be perceived professionally inappropriate for a doctor to agree that the illness is insignificant. Here, a patient downplays the gravity of his upcoming bowel surgery by using simplified language and expressing positive attitudes towards the doctor's diagram of his operation plan:

P: I like the nice little picture,
it's not a big bit coming out
[laughs]
W: [laughs]

In this instance, the patient 'laughs off' his own positive AFFECT and APPRECIATION because they are not sincere: the participants cannot commune around the idea of the operation being 'nice' or 'like[d]' because it is not. In doing so he also defers his trivialisation of the surgery as this is not a value the participants can bond over either; thus they defer to an implicated bond around the actual seriousness of the issue. The patient's wife also laughs at this expression, displaying similar avoidance of the proposed valuing and trivialisation.

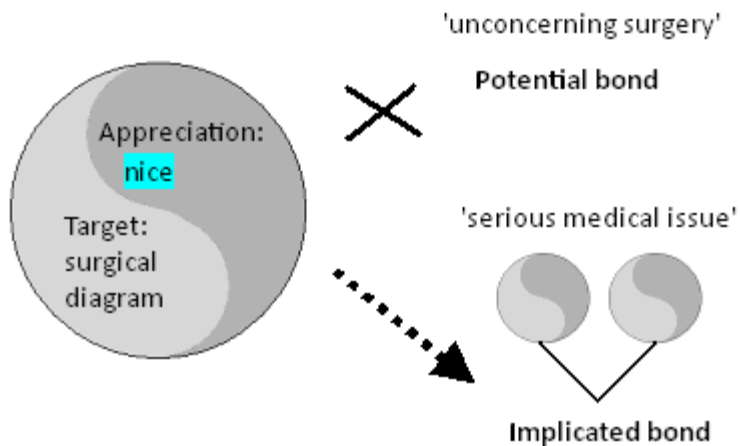


Fig 3.8: nice + surgical diagram construes a potential bond trivialising the surgery, which is deferred, and instead an implicated 'serious medical issue' bond is deferred to.

The participants also choose not to commune around expressions of the patient's weakness, such as in the following example when, after the patient's wife has built up an expression of frustration about hospital cancellations, the doctor explicitly acknowledges the patient's anxiety using negative AFFECT. The wife follows this up by invoking more negative emotion, but then laughs it off, preventing them from bonding around the patient's weakness.

- D: and so on top of the anxiety that you would have coming into surgery anyway
W: psyching himself up each time
[laughs]
D: ah dear (5)

In this instance the doctor does follow up with a VALIDATE response, demonstrating empathy for the patient's suffering. However this expression has already been laughed off; the doctor's response does not constitute a successful bonding exchange since the other participant has already deferred it.

3.4 Conclusion

This chapter has summarised the choices available to doctors when responding to emotional or attitudinal expressions, and introduced a new graded model that categorises the options they have according to the level of empathy each conveys. These categories have been characterised linguistically using a combination of APPRAISAL, back-channel functions and intonation theories, in an attempt to provide a model that not only categorises existing examples of responses but also allows the creation of further possible responses in each category.

Chapter 4 analyses how these different responses are used in the consultations studied. It examines how these patterns relate to the ideational and interpersonal content of the consultation discourse, and to some of the empathic communication strategies taught in medical education.

Chapter 4: Empathic responses in context: patterns in use

This chapter exemplifies how each of the different response types can be used in interpersonal medical communication and the main patterns in which they occur. Firstly, section 4.1 looks at each response option in turn, identifying the correlation their use has with the ideational content being discussed (field) and the type and strength of ATTITUDE being conveyed – to investigate how the different degrees of empathy can be appropriate in different circumstances. Then in section 4.2 further analysis of the logogenesis is carried out, considering the way expression+response pairs build and interact in a conversation, again in relation to nature of the field and ATTITUDE being conveyed. Overall, this chapter examines the patterns in which different responses are used by a doctor respected for his successful empathic communication, in order to identify which seem most effective for the development of interpersonal rapport and to characterise the circumstances in which each may be used.

4.1 Responses in individual bonding exchanges

In this section, the interactants' communication is analysed for the types of expressions that prompt the different responses. The instances in which each response option is used are examined, to identify patterns in the association of these responses with the topics being discussed. This is extended to a proposed description of how doctors can respond appropriately in different situations of interpersonal communication.

Although bonding exchanges can be examined individually as a pair of utterances comprising the patient's empathic opportunity and the doctor's response, it is important to understand that empathic exchanges often occur and develop over multiple conversational moves. Following this section's overview of the patterns in use in context of the single exchange, section 4.2 will examine how they can build on each other, and how the empathic contours of these 'exchange complexes' (see 4.2 for definition) form a significant component of understanding how empathic communication functions in the consultation.

4.1.1 LISTEN

LISTEN responses are frequently used in situations of information gathering, where the patient explains symptoms, their location and duration, and gives information about previous or current treatments. Although these descriptions do invoke emotion, and often include other inscriptions of ATTITUDE, it seems they are considered more as an information gathering exercise, not requiring engagement with the underlying emotional content. LISTEN allows the conversation to continue, providing support that demonstrates listening ('comprehension' back-channels) and/or encouragement for the speaker to continue ('continuers': definitions from Gardner 2001). LISTEN responses frequently occur during the build-up of an emotional interaction, before the doctor displays more clinical empathy by using another, more engaged response (section 4.2 discusses these 'exchange complexes'). LISTEN allows patients to continue expressing their perspective by encouraging them through an indication of active listening. This 'facilitative' data gathering function is one that is taught in medical communication (e.g. Gask & Usherwood 2002).

Interestingly, in these consultations LISTEN responses are used by the patients and kin more than by the doctor. This is reflective of the tenor of the consultation context, where the doctor is at a higher power level than the other participants, seen as a source of medical knowledge and solutions. Since it is the patient, who usually offers the emotional expressions to which an empathic response is expected, responses given by patients/kin are more often to acknowledge receipt of information given by the doctor. In these situations a LISTEN response such as *mmhm* is appropriate to acknowledge hearing.

4.1.2 ACKNOWLEDGE

The ACKNOWLEDGE response appears to be used in situations where AFFECT is invoked, in expressions that often occur at the start of empathic exchange complexes which build to more explicit attitudinal expressions. For example, preceding a discussion about problems at work, one patient hints at emotional issues by talking about letting 'it all hang out' for her other doctor, to which the doctor gives an ACKNOWLEDGE response ('ok'). This response acknowledges

that there is some emotional content in what has been expressed, even if the AFFECT is too implicit to bond over yet. It shows some concern for what the patient is divulging and encourages further expression.

It also appears when negative AFFECT is invoked in expressions of disruption, such as a family member's description of confusion about treatment: 'we weren't sure about prep'. This exchange complex then builds from invoked to inscribed emotion ('got...confused') and receives increasingly empathic ACCORD and VALIDATE responses as it does. This demonstrates how lower empathic responses can map to more implicit expressions before increasing in empathy as the emotion becomes more clearly conveyed (as illustrated in Figure 4.1). Section 4.2.1 analyses this contour pattern including further examination of this conversation (see in particular Figure 4.11 for an extended version of Figure 4.1).

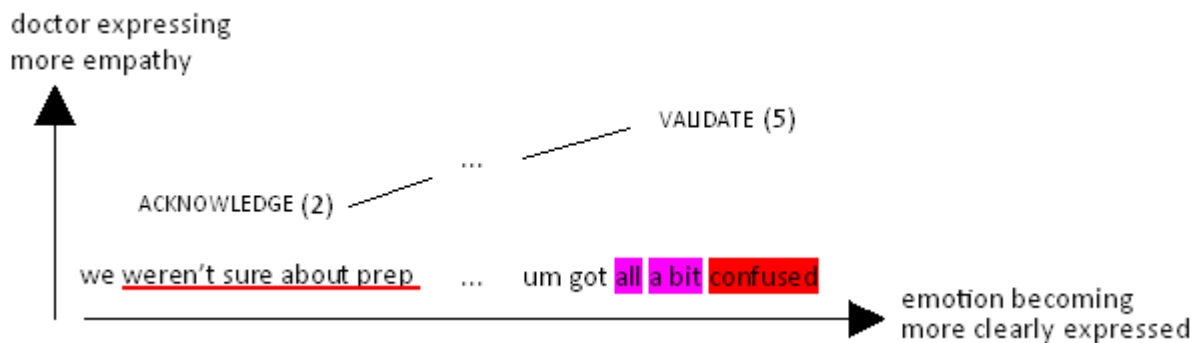


Fig 4.1: ACKNOWLEDGE building to VALIDATE as emotion is expressed more clearly

Interestingly, ACKNOWLEDGE responses are also used to respond to positive comments made by the patient, such as being 'not worried' about the illness, 'not bother[ed]' by the pain, not needing to use medication, or being content to 'wait and see'. Giving an ACKNOWLEDGE response allows the doctor to demonstrate comprehension of the positive expression without aligning himself with it, perhaps as a means of avoiding the appearance of downplaying the patient's condition. Indeed sometimes patients/kin laugh off their own trivialisation of the issue before the doctor responds, indicating this value is not something they choose to commune around (see section 4.1.7). Thus even in situations where patients, kin and doctor do not laugh it off, ACKNOWLEDGE provides a tactful way for the doctor to offer acknowledgement without agreement (as does SUPPORT, which will be discussed in the next section).

4.1.3 SUPPORT

SUPPORT takes the form of positive judgement of the patient or his/her behaviour, including validation via 'normalisation' (confirming the patient's behaviour or feeling as acceptable by calling it normal; advocated in doctor-patient communication, e.g. Sperry 2008). However despite expressing its normality, the doctor does not validate the actual content of the response, perhaps because it is an attitude with which it would be deemed inappropriate for a doctor to align.

In the consultations studied, these responses seem to occur most often when patients downplay the severity of their suffering or make negative comments about themselves, and examples of these situations will be discussed below. An offer of neutral SUPPORT seems appropriate in these circumstances as attitudes and emotions are clearly being discussed and require acknowledgement from the doctor. However actual agreement would be inappropriate as it would indicate the doctor agrees with the negative judgement of the patient or the triviality of the condition – neither of which convey respect and concern.

In this example (introduced in section 3.2.3) the patient downplays the extent of his current condition by explaining how he has suffered worse things previously.

P: I had worse than that

D: you're a very tough guy (3)

Here the doctor does not confirm the patient's statement that he has suffered 'worse' things, but does validate the expression by giving positive judgement of the patient ('very tough'). If the doctor had agreed with the patient that his prior condition was more concerning, it could be seen as endorsing his trivialisation of the current medical issue, suggesting that the doctor does not take his condition seriously.

Below is an example (also presented in 3.2.3) of the doctor using normalisation to legitimise a patient's feelings without directly confirming her negative self-judgement. Here they are discussing the embarrassment of the physical examination as the patient is preparing for it:

- P: oh no that's fine with the curtains xxx
I lost my dignity with this years ago
[laughs]
- D: everybody says that (3)
I'm not sure if they if it's really true
is it?
- P: I don't know
partially [laughs]
- D: certainly it helps having practice, doesn't it?
- P: yes

Instead of confirming that the patient has indeed 'lost [her] dignity', or allowing the bond to be deferred when she attempts to laugh it off, the doctor chooses to normalise her sentiment by telling her that 'everybody says that'. He follows up by attempting to disagree with her, and they negotiate the loss of dignity in a more neutral way in terms of 'everybody', not only the patient herself. The doctor is hesitant to confirm the patient's negative self-opinion as it would suggest he agrees that she is, in this case, undignified, and thus put potential strain on the relationship: this is a situation in which the neutral SUPPORT option appears most appropriate. As discussed in section 3.2.3, this response enables the doctor to re-shift the focus to the invoked emotion beneath the negative self-judgement, deferring to the implicated bond of the patient being uncomfortable. By normalising her response with respect to it being how 'everybody' feels, the doctor provides 'neutral support' for the patient. He thus shows that her views are legitimate although he cannot approve them due to perceived inappropriateness (as in Pounds' model, 2011).

SUPPORT can also be used to respond to attitudinal expressions that do not invoke negative emotions but are still negative self-judgements. In the following consultation the young adult male patient talks about being bad with remembering names.

D: have you been out to see um [other doctor]?

P: ah

D: in the outpatients

you may not've

P: I don't know what

D: ok [laughing]

P: I'm **no good** with names

so I =might of

D: =no **fair enough** (3)

Unlike the previous example, where emotions were being negotiated underlying the patient's supposed loss of dignity, in this extract the doctor is responding to self-criticism that does not clearly invoke emotion. Here the doctor does not see the need to disagree with the patient or attempt to negotiate the judgement; at the same time to agree with it directly would seem to equate to an insult. Accordingly the judgement is met with SUPPORT as the doctor tells the patient his inability to remember names is 'fair enough'.

4.1.4 ACCORD

When patients/kin express opinion or emotion explicitly (inscribed APPRAISAL), a more engaged response is used, including the ACCORD responses that demonstrate this understanding, or VALIDATE responses which directly state it (eg 'yeah' vs. 'what a nuisance'). These responses can occur in exchange complexes, as discussed in section 4.2. ACCORD may occur after a sequence of lower level responses in a situation where empathy develops gradually (see section 4.2.1). Alternatively, it may be the initial response to an empathic opportunity which is then followed by LISTEN or ACKNOWLEDGE to gather further information (see section 4.2.2).

It is worth noting that the ACCORD response may sometimes be deemed more appropriate than VALIDATE or SHARE. The generally perceived inappropriateness of the SHARE response will be discussed in the next section, but it seems that even the next highest demonstration of empathy

is not always more suitable than less empathic responses. Gardner suggests that a marked *mm* – the ‘minimal sympathetic response’ – can express not only affiliation but also ‘the inability to express it in words’ (2001:243). Accordingly, doctors may be able to convey high degrees of empathy using ACCORD to indirectly validate significant emotions, implying that they understand these emotions so much they find it difficult to verbalise directly (Gardner 2001:243).

4.1.5 VALIDATE

VALIDATE extends on ACCORD by directly stating the understanding or validation of the patient’s expression, either through verbs of understanding or inscriptions of ATTITUDE. This conveys a greater degree of empathy and is usually used to respond to direct inscriptions of emotion and other inscribed (and often graded) ATTITUDE towards medical experience – both positive and negative.

In the following example, a patient’s wife describes the confusion they felt leading up to the colonoscopy, as they were unclear about the preparation and seemed to have been getting confusing information from hospital staff.

- W: um and we were unclear
we were just going to follow the the prep that he did for the colonoscopy
- D: yeah good [high fall] (4)
- W: um but they said not to do that
you don’t have to do any prep
so we all got a bit you know
- D: yeah [high fall] (4)
- W: just lack of information
- D: yeah [high fall] (4)

The patient’s wife directly inscribes negative APPRECIATION about the hospital process (‘unclear’), invoking AFFECT (confusion) through expressions of disruption and contradictory information. This evokes an engaged response from the doctor. His ACCORD response indicates agreement

with the value presented, and the interlocutors commune around the proposed bond of confusing hospital procedures.

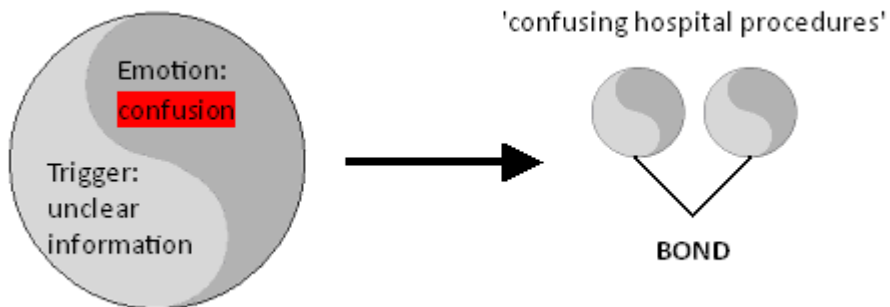


Fig 4.2: confusion + unclear information construes a bond of 'confusing hospital procedures', communed around through the doctor's indirectly-validating ACCORD response

His understanding is conveyed implicitly here through the ACCORD response: he does not offer explicit validation of the family's confusion (e.g. *yeah that would be confusing* or *yeah I understand*). In fact, this conversation continues further, and section 4.2 of this chapter will examine how moving to inscribed AFFECT can elicit more empathy.

4.1.6 SHARE

In casual conversation, description of troubles would usually be expected to be followed by some affiliative response, commonly 'an affective response in which [responders] show their position on the described situation' (Ruusuvuori 2005:204). Sacks, whose work formed the basis for the development of conversation analysis, described explicit sharing of emotion or experience as one of the most efficient means of demonstrating affiliation (1992:vol 2). Despite this, such responses are uncommon in doctor-patient communication and, in fact, supposedly excluded from appropriate response options in professional interactions (Ruusuvuori 2005:204). Bylund & Makoul also found, through patient surveys, that patients do not desire SHARE responses (2002:214). Bylund considers this to be different to empathic concern: she calls shared feeling/experience 'emotional contagion' and considers the next level down the highest

level of empathic concern (2001:161). This study also found the share response very infrequent (1.7% of responses) in doctor-patient language (Bylund 2001:161).

Reasoning behind this could relate to patients' desire for power levels to remain somewhat imbalanced in the consultation context – i.e. wanting doctors to be the professional, knowledgeable figures so that they can be trusted to solve the problems presented. It would thus be deemed inappropriate for doctors to share emotions such as the patient's anxiety or confusion, as this damages the doctor's power status. Bonding over shared emotion lessens the professional distance, reducing the doctor to the patient's emotional level; this appears usually undesirable.

In some circumstances, however, it is possible for the doctor to demonstrate empathy through shared experience without affecting his status as the problem solver, such as in the example given in section 3.2.6 (the only SHARE response of the 350 analysed). While discussing any pre-colonoscopy bowel control issues the patient might have suffered, the doctor chooses to share his own ('I surprised myself'). This allows the participants to bond over the shared experience and discomfort, but does not prevent the doctor from having the power to give knowledge and diagnoses in the context, since the emotions shared are relating to an examination procedure and not, for example, overall anxiety about the illness.

Ruusuvuori states that patients essentially expect the doctor to provide a solution to their problem – a 'task-related response' – and that an overly affiliative response can limit their ability to provide this (2005:204). The rarity of such responses in studies of doctors' communication supports this idea that patients do not want their doctors to empathise with them completely (to the extent of sharing their emotions and experience) if it prevents them from doing their job of solving the problem. Rather it is best for professionals to display recognition and understanding whilst still maintaining some position of expertise (also see Wright 2004).

The modern push for 'patient-centred care' (Institute of Medicine 2001) is supported by results from patient questionnaires (e.g. Little *et al.* 2001). However in practice it appears patients still want, to some extent, to defer to doctors as authoritative figures responsible for making the decisions, and thus maintain some degree of professional distance. As Tebble describes, the

participants have a 'formal but friendly' social distance (1999:189). In SFL terms, this relates to the register of the ideal medical consultation, which has positive solidarity between the participants but an imbalance of power: unequal status. Martin situates this 'status-like relationship' of power in SFL's models of social context by describing it from the perspectives of register ('context of situation', comprising field, tenor and mode) and genre ('context of culture') (1992:495,526). Following this explanation, the doctor's position of power can be seen as composed of the following: 'authority' in how classification as a physician and his medical expertise position him in society (field), 'status' for his high relative position in the social hierarchy (tenor), 'prominence' given by various media's construction of medical professionals (mode) and 'control' in the way he leads the conversation in the consultation, directing the other participants (genre) (Martin 1992:527). It appears that patients do want to achieve and maintain solidarity with their doctors but also to retain this power imbalance, with doctors remaining the figures of expertise.

4.1.7 Laughing affiliation: deferring unshared potential bonds

In the consultation context, where the doctor's role is to solve the patient's medical issue, there are some values discussed around which the doctor and patient cannot commune. This section examines the sorts of evaluative couplings around which the participants in the consultations choose not to bond and where they instead laugh off the empathic opportunity, anticipating the doctor's inability to make an appropriate empathic response in the current situation ('laughing affiliation': Knight 2010).

Examples of evaluative couplings that cannot be shared include making light of the illness, negative judgements of interacting participants and negative opinions of hospital staff or facilities. Some examples of laughing affiliation follow.

When the patient or family express concern about the medical condition, a doctor can acknowledge this expression and sympathise with the patient through acceptance of the proposed bond of concern. However, it appears a doctor must respond differently if the patient tries to trivialise the condition, as it would seem inappropriate to agree it is insignificant. An

example of this was introduced in section 3.3.1, where the patient laughs off his positive AFFECT and APPRECIATION to avoid communing around the idea of the surgery being 'nice' or 'like[d]':

P: I like the nice little picture,
it's not a big bit coming out
[laughs]

Another example of this patient trivialising his operation occurs when he tells how his children have demonstrated the surgery on an animal at their farm:

P: the kids have done a demo- demonstration
[laughs]
D: have they?
W: yes
P: but they tied a bow in it
and then when you need to go to the toilet you undo the bow
[laughs]

Here there is no inscribed attitude but his humorous story about the children pretending to do his surgery on a sheep implies a lack of concern that is incongruent with the seriousness of his upcoming surgery. The patient signifies this discrepancy by laughing, showing that this downplaying is not a value they can bond over – again deferring to an implicated bond over his concerning medical needs.

Other studies have found that patients laugh much more than doctors during consultations (e.g. Haakana 2001; West 1984; Adelswärd 1989), and this pattern is also evident in the data considered here. For example, the doctor does not laugh in these situations of the patient downplaying his problem; instead it is the patient or kin who laugh off the proposed bond. That is, although the doctor does not accept the bonds, he does not reject or defer them either. In the first example above (P: 'I like the nice little picture'), he remains silent as the wife and

patient laugh, allowing the ‘unconcerning surgery’ bond to be laughed off without involving himself (see Figure 3.8 in section 3.3.1). In the second example (P: ‘the kids have done a demo’), the doctor facilitates the patient’s story with an encouraging question (‘have they?’) and does not laugh with the patient. This suggests he is not willing to laugh off the issue even though he cannot accept the bond. By not deferring to ‘laughing affiliation’, the doctor keeps the option for ‘communing affiliation’ open (terms from Knight 2010; see section 2.1.2), allowing the patient to elaborate and acknowledge any concern behind his humorous story if he chooses to.

The participants also do not bond around negative judgements of one another. Section 3.3.1 introduced an example of the patient’s wife laughing off her comment about ‘psyching himself up’:

D: and so **on top of** the **anxiety** that you would have coming into surgery anyway

W: psyching himself up each time

[laughs]

D: **ah dear** (5)

The doctor does follow up with a VALIDATE response (‘ah dear’) but the wife has already deferred the bond, choosing not to commune around the patient’s weakness. In another example of negative judgement being laughed off, below the doctor proposes a potential insult of a patient. It is laughed off by the patient and his wife – they cannot bond over an insult – but not by the doctor, who instead appears to try to counter the insult with a compliment:

D: you’re a **hoot**

W&P: [laugh]

D: no you are you’re **terrific**

W: [laughs]

After the patient denies being on any medications and his wife contradicts him by naming one, the doctor’s statement ‘you’re a hoot’ seems to refer to the patient’s forgetfulness or lack of understanding. The patient and his wife both laugh off the tension caused by the initial judgement that they do not want to share, and then when the doctor counters this with a more

positive judgement the wife laughs off the compliment as well. This avoidance of accepting compliments occurs again below where the patient and his wife laugh off the patient's positive self-judgement:

P: I just think I'm important

W: [laughs]

P: [laughs]

Tension is also created when it is the doctor who expresses negative self-judgement, such as when he suggests his jetlag prevented him from realising the patient's sister is a nurse:

D: if I'd been smart

if I hadn't been jetlagged

S: I've been very quiet

D: Yeah but I would- know

I would've asked you

I would've said now who's a nurse?

All: [laugh]

All participants laugh off the doctor's negative self-judgement as they recognise his expression as something they cannot bond over. In a situation where the patient's health depends upon his abilities, they cannot commune around the idea that these are impaired. Laughing this off enables them instead to rally around the implicated bond of his medical competence.

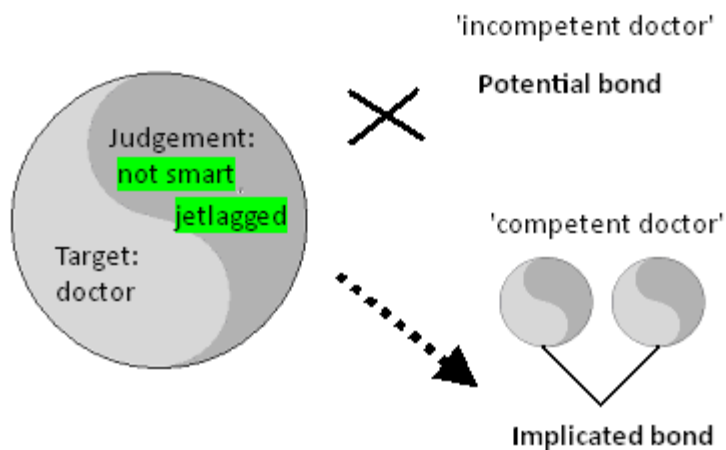


Fig 4.3: coupling of not smart & jetlagged + doctor construes a potential 'incompetent doctor' bond, which cannot be rallied around and so is laughed off to defer to the opposite implicated bond.

Other evaluative couplings that cannot be shared include the doctor's expression of keenness to operate on the patient (after it has been established that the patient is uncommonly relaxed):

- D: I'm **looking forward** to operating on you
 [laughs]
 All: [laugh]

Since it would be inappropriate to share the doctor's positive anticipation of performing invasive bowel surgery, this too is avoided through laughter by all participants, and they defer to the implicated bond of the seriousness of the upcoming operation.

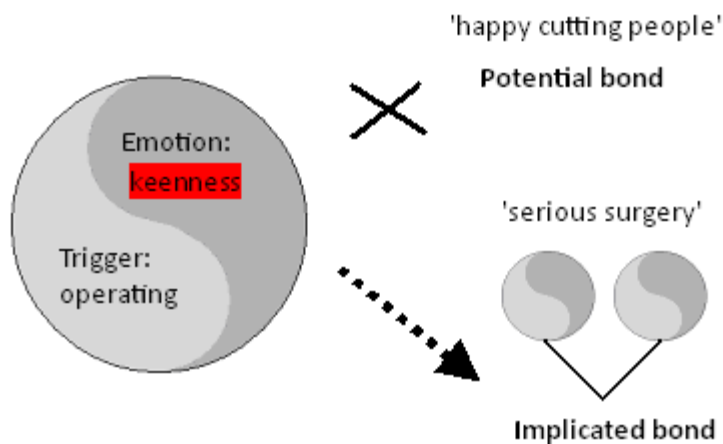


Fig 4.4: keenness + operating construes potential bond of doctor enjoying cutting people up in surgery, perceived as inappropriate and so laughed off in favour of implicated 'serious surgery' bond.

The participants also recognise that they cannot share negative evaluations about hospital personnel, as the doctor professionally cannot support these opinions. In the example below, the patient's wife expresses their confusion about surgery preparation, implying disorganisation and unhelpfulness on the part of the hospital staff.

W: I suppose we were getting **confused** with the colonoscopy prep

D: yeah

W: and this cause some were saying no you don't need it
and others were saying just have a light diet and xxx

[laughs]

In this example, the patient's wife recognises that her evaluation of the staff creates affiliative tension and laughs it off in acknowledgement of the fact that the doctor cannot accept this bond. In doing so, she defers to an implicated bond of hospital staff competency.

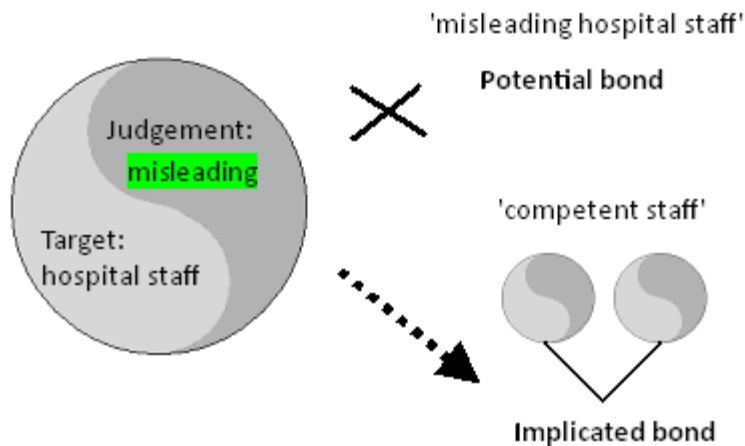


Fig 4.5: misleading + staff coupling construes potential bond over negative judgement of staff, laughed off by patient's wife to imply a bond of staff competence, which the doctor can support.

In addition, sometimes there are ideas expressed around which the participants simply cannot bond because their values differ too considerably. For example, when the doctor asks if the patient uses pilates to help with his back problems:

- D: you do pilates class with the
P: oh no
W&P: [laugh]
D: [laughs]
you draw the line at that?
P: oh well xxx it's an hour out of town
D: yeah **actually** that's the **truth** isn't it?

The patient rejects the idea of him doing pilates, and he and his wife also laugh it off, followed by the doctor; it is only when he probes for further information that they provide a practical excuse. Yet they would have done this first if they considered pilates an activity they could appreciate in their community.

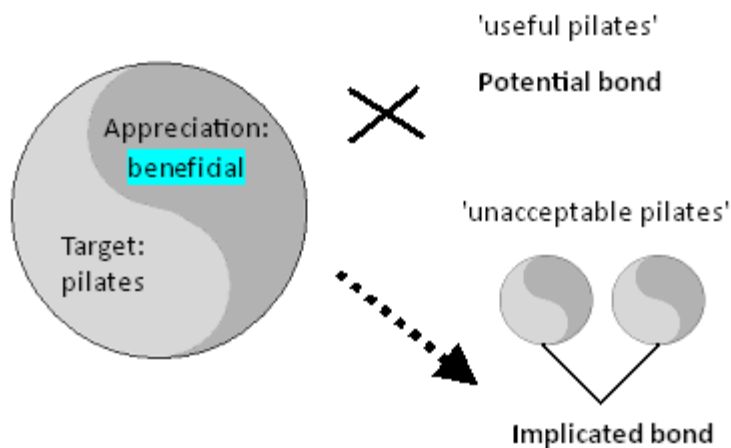


Fig 4.6: proposed coupling of beneficial + pilates laughed off in favour of implicated bond over pilates being socially unacceptable, perhaps unmanly, for the patient.

Haakana's conversation analysis of laughter found that patients laugh 'to deal with delicate aspects of medical interaction' (2001:213). That is, it occurs in situations where patients have to 'momentarily portray themselves in an unfavorable light', by somehow contradicting the doctor or expectations of what constitutes good patient behaviour (Haakana 2001:213). This research supports the 'laughing affiliation' (from Knight 2010) analysis here of laughter in medical consultations, providing further evidence for its use in situations where the bonds proposed create affiliative tension. The patients recognise they are 'portray[ing] themselves in an unfavorable light' (Haakana 2001:213) and that communing around this value would not benefit the doctor-patient relationship, so they laugh off the tension created by the proposed bond.

Participants defer several proposed bonds through laughing affiliation, for various reasons. They laugh at negative judgements to avoid creating a social bond around a potential insult. The patient may laugh off his/her medical suffering, although a doctor with good empathic communicative skills will not defer this bond himself; instead he will attempt to acknowledge the patient's concern and facilitate further expression. The fact that the doctor in these situations rarely laughs off any potential bond signifies a kind of empathy whereby he acknowledges and validates patients' expressions, indicating that their concerns are legitimate, significant and understandable; the doctor also shows that he is interested in helping the

patients to resolve them. It does this by keeping the option for communing open, if the patients choose to elaborate on their concerns and propose a similar bond that they do want to rally around.

4.2 Empathy as a bonding exchange complex: logogenesis

Whilst the expressions and responses can be considered in individual exchanges ('empathic opportunity' (term from Bylund & Makoul 2002:209) + response), they often build on each other over several conversational moves. Accordingly these opportunities must also be examined in context as a sequence of such exchanges builds to form a larger empathic exchange complex over an ideational topic. This notion is generally not addressed in existing medical empathy models: for example, Sandvik *et al.*'s conversation analysis based critique of the RIAS noted that the focus on opportunity-response pairs and explicit statements of emotion does not allow for empathy to be expressed as a gradual process (2002).

The characteristics of each individual exchange are certainly important and form the basis of this analysis in considering the types of expressions that prompt different responses. However since they can occur in sequences developing discussion of the same concern, the interaction between these exchanges must also be considered. Empathic exchange complexes are defined here as a series of one or more empathic exchanges around a specific interpersonal expression linked with a specific ideational topic. This enables analysis of how the level of empathy conveyed can fluctuate with each exchange, building an overall empathic contour across an exchange complex. Empathic communication is therefore considered here not only in terms of the individual exchanges, but also how they pattern together to form a sequence of exchanges and how the interpersonal interaction between the participants builds and fades over this complex.

4.2.1 Increasing emotion receiving increasing empathy

Empathic exchange complexes may take the form of an attitude becoming clearer over a sequence of expressions in which invoked attitude becomes increasingly explicit until eventually it is directly inscribed. In the following example the patient expresses concern about his upcoming operation and the potential side effects. The doctor has been describing the surgery and a number of risks, and the patient starts to show apprehension. At first he does this indirectly, stating that he does not need to hear 'all the information' (note no attitude is inscribed, only some graduation: to 'flag' the invoked attitude). The doctor initially offers a lower empathy ACKNOWLEDGE response. The patient and his wife attempt to defer the bond by laughing it off, but the doctor acknowledges the bonding opportunity again by offering a SUPPORT response that confirms to the patient that his concern is acceptable.

P: I don't need to know **all** the information

D: Ok alright (2)

W,P: [laugh]

D: [smiles] no that's **important** (3)

Following this are two more exchanges initiated by the patient's sister, discussing how his wife 'probably would like to hear it'. The doctor then begins to change topic, but the patient continues the complex by making his concern more explicit. It may suggest he is yet dissatisfied with the degree of empathy conveyed. He introduces appreciation of his family's behaviour as 'trouble', referring to when they spend time researching potential side effects. This comes closer to invoking emotion (via inscribed appreciation) as the suggestion behind this expression is that the behaviour 'trouble[s]' the patient. The doctor then gives an ACCORD response, showing a higher level of empathy.

P: the **trouble** is at home people get on the computer and they do **all** these

D: yeah [high fall] (4)

P: things and they say oh you might get this you might get that

D: yeah [high fall] (4)

This interpretation of affect being invoked in the inscribed appreciation can be related to the idea that JUDGEMENT and APPRECIATION both evolve from AFFECT, as feelings ‘institutionalised’ or ‘reworked’ into proposed judgement around good behaviour and appreciation of the value of things (Martin & White 2005:45):

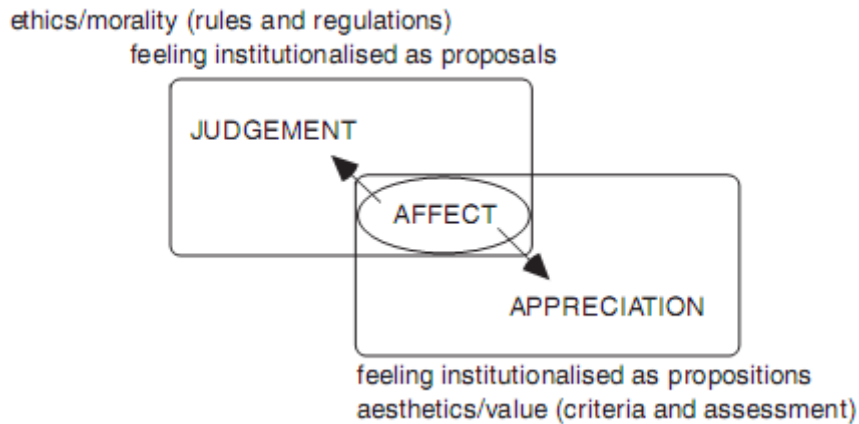


Fig 4.7: JUDGEMENT and APPRECIATION as insititutionalised AFFECT (image from Martin & White 2005:45).

The idea that views about people or things have stemmed from emotions supports the suggestion that the patient’s concern is made more evident when he inscribes negative appreciation of his family’s actions. Subsequently the patient makes his feelings even clearer by describing himself as ‘the poor bugger getting it’; here emotion is more clearly invoked by the negative self judgement, emphatically construing feelings of self-pity:

P: And I’m the **poor bugger** getting it

[laughs]

D: I know, **you are** (5)

To this expression the doctor gives a high level, VALIDATE response that confirms and legitimises the patient’s concerns (effectively repeating them through elision: ‘you are’), accepting the proposed bond to commune around the patient’s worry about the surgery:

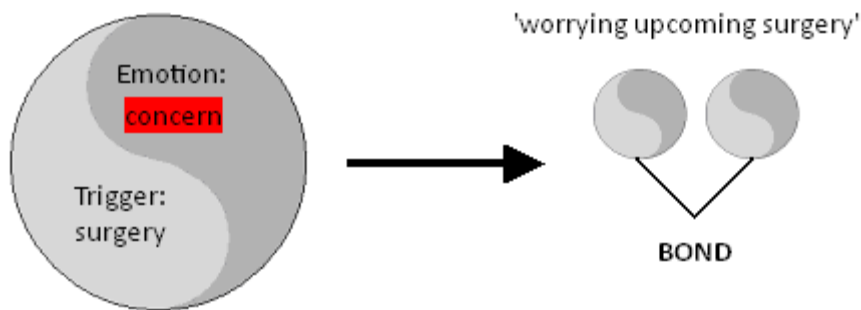


Fig 4.8: coupling of concern + surgery construes a 'worrying surgery' bond, communed around through the doctor's validating responses

Of note in this example is the fact that the patient attempts to defer the bond before the doctor can respond, since it is usually inappropriate to bond over negative self-judgement (see 3.3.1, 4.1.7). Yet in this case the doctor still responds with empathy, perhaps due to recognition of the underlying emotion being conveyed with the inscribed judgement. In other words, he is willing to accept the patient's concern about his condition and careful not to align himself with the downplaying of the issue. As discussed previously, the doctor rarely defers a bonding opportunity though laughing affiliation; rather he gives no response or a lower level, more neutral one, sustaining the possibility for communing (see 4.1.7). Since the patient's negative judgement seems in this case to be more reflective of underlying anxiety than of a negative opinion of himself, it is a value the doctor can affiliate with and show concern for. Thus it receives a validating response instead of neutral support (cf. the negative judgements 'lost my dignity' and 'no good with names' in section 4.1.3). This conveys a greater sense of empathy and rapport and functions to validate the patient's concerns, facilitating further expression.

Figure 4.9 below summarises the exchange complex this section has analysed, by illustrating its empathic contour.

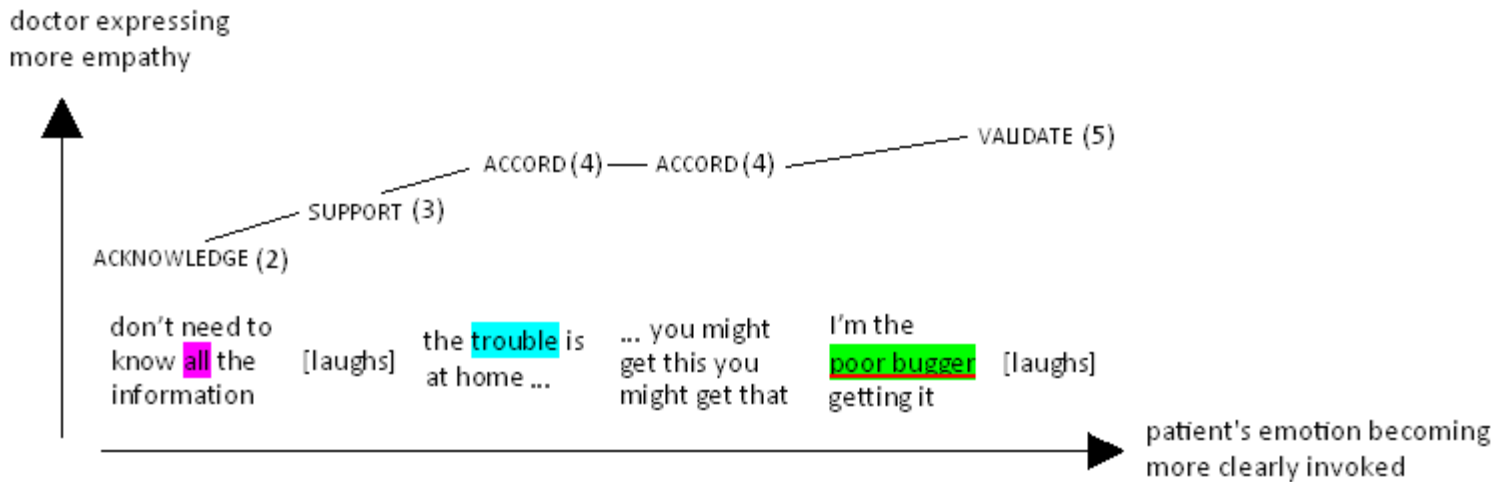


Fig 4.9 empathic contour of the exchange complex: doctor's responses convey increasing degrees of empathy as the patient expresses his emotion more directly

Section 4.2.1 discussed another example where invoked affect ('we weren't sure about prep') builds to inscribed ('got...confused'), receiving increasingly empathic ACCORD and VALIDATE responses as it does. This again illustrates how the level of empathy conveyed by the doctor can grow in proportion to the clarity of the emotion expressed (see 4.2.1).

Suchman *et al.* identified similar patterns, where emotions may first be presented subtly, as 'potential empathic opportunities' (by their own terminology) before emerging more clearly if the doctor offers an encouraging response (1997:680). This explicit empathic opportunity is then more likely to receive explicit acknowledgement from the doctor in the form of an empathic response (Suchman *et al.* 1997:680). Although the definitions have been revised in this thesis, the same patterns are evident, with the doctor being more likely to respond with explicit statements of understanding, or higher degrees of empathy, when the patient inscribes the attitude instead of invoking it.

It could be interpreted that patients use the technique of initially hinting at their emotional concerns and then gradually making them more explicit because they do not want to seem troublesome or 'whingey' by stating their problems too clearly but still want the doctor to acknowledge them. It may also be that since doctors often miss hinted concerns (e.g. see

Ruusuvuori 2007:604; Suchman *et al.* 1997:679), patients build on these exchanges due to dissatisfaction with the low level of empathy in the doctor's responses.

Also interesting is the point where these complexes end – presumably the point at which the patient is satisfied they have elicited an adequately empathic response. This is usually at a level 4 (ACCORD) or 5 (VALIDATE) response, indicating these two options are often the most desirable. The following example, introduced in 4.1.5, shows a build from indirect (level 4) to direct (level 5) validation.

- W: um and we were **unclear**
we were just going to follow the the prep that he did for the colonoscopy
- D: yeah **good** (4)
- W: um but they said not to do that
you don't have to do **any** prep
so we **all** got **a bit** you know
- D: yeah (4)
- W: just lack of information
- D: yeah (4)
- W: and um got **all a bit confused**
- D: yep (4)
- W: yeah
- D: no I can understand (5)

Initially the doctor offers ACCORD responses ('yeah'), then increases this to a VALIDATE response with his explicit statement 'I can understand'. This demonstrates to the patient and his family that the doctor recognises their concerns and understands why they are feeling confused about the operation. Making the validation explicit confirms the communing affiliation by directly accepting the proposed bond that had previously only been implied (both in its proposal through invoked affect, and its acceptance through an ACCORD response).

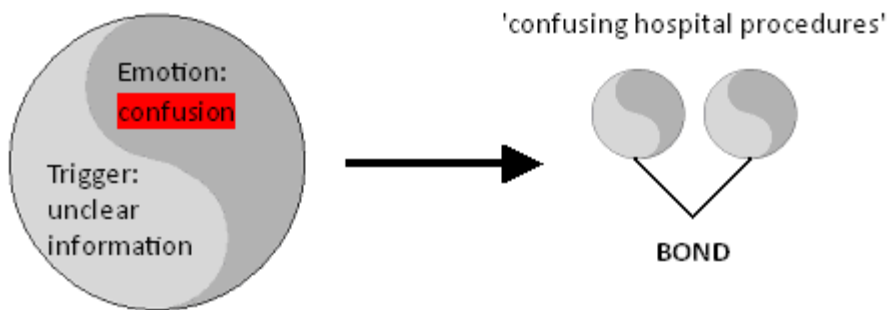


Fig 4.10: confusion + unclear information construes a bond of 'confusing hospital procedures', communed around through the doctor's validating response

The doctor only changes from ACCORD to VALIDATE after the wife directly inscribes her emotion ('confused' vs. the implicit confusion invoked by 'unclear' and 'lack of information'). This is an example of the contour of clinical empathy that builds around empathic exchanges – the participants bond over the confusion that is expressed over a number of conversational exchanges and increase the empathic strength of this bond as the conversation continues to build on this description of emotion (see Figure 4.11).

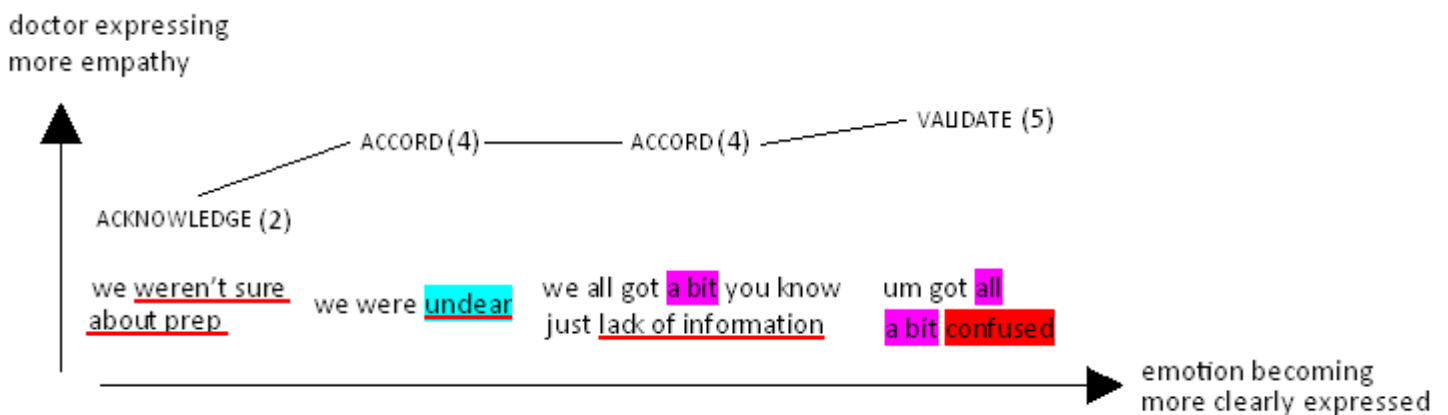


Fig 4.11 empathic contour of the exchange complex: doctor's responses convey increasing degrees of empathy as patient's wife expresses concern more directly (extended from Fig 4.1)

This also suggests that when patients/kin think the doctor has not responded adequately to their hinted emotion and want a greater empathic response from the doctor, they may use direct inscription of affect as a means of making their feeling clearer.

4.2.2 Initial high empathy subsequently fluctuating during elaboration

Exchange complexes may also occur in the pattern of a high initial expression of empathy then a fade to lower level responses, and then (potentially) another high level response at the culmination of the sequence. This occurs, for instance, when a patient initially inscribes emotion to which the doctor responds with a high degree of engagement, then elaborates with further information, which the doctor tracks with responses more indicative of active listening than heightened emotion. Then at the culmination of this information and before moving on to a different topic, the doctor may choose to reaffirm the significance of this emotion by again conveying a higher level of empathy. This is the case in the following example (discussed in section 3.2.4).

When this patient describes to the doctor her troubles with colleagues being immature and unsupportive about her bowel condition when she tried to return to work, the doctor gives an initial high empathy ACCORD response. He then switches to LISTEN before building to another more engaged ACCORD.

- P: 'cause some of the girls are being less than supportive
- D: mm [high fall, longer] (4)
- P: and very juvenile
- D: mm [low fall, shorter] (1)
- P: um and also there's a majority of the work I'm not physically
- D: yes (4)
- P: sort of able to do
- D: yeah (4)

Although the doctor gave a highly empathic response to the patient's first judgement of her colleagues as 'less than supportive', he only gives a regulatory LISTEN acknowledgement of her elaboration that they are 'very juvenile'. Then as she continues to describe the difficulties she faced in returning to work, the doctor responds with greater degrees of empathic concern. This

exemplifies how the level of empathy expressed can fluctuate during an exchange complex, and this contour is illustrated in Figure 4.12. It likely relates to how there is invoked emotion (feeling unsupported) in the negative judgement of others as ‘less than supportive’, but none further invoked by ‘juvenile’, which can thus be tracked with a LISTEN response. It may also suggest that it would seem strange or insincere for a doctor persistently to give highly engaged responses even when emotion is established: this could explain the use of LISTEN to track her elaboration before returning to ACCORD to acknowledge the significance of the emotional expression at its culmination.

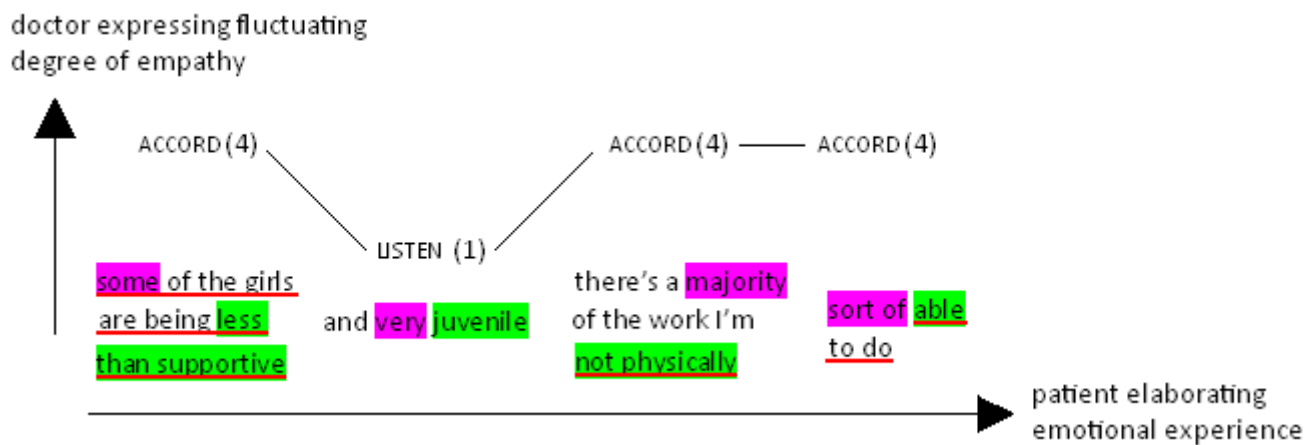


Fig 4.12: empathic contour of the exchange complex: doctor's responses fluctuate in degree of empathy conveyed as the patient elaborates

Below is an example where the patient's initial expression includes clear negative emotion, albeit invoked, and so the initial response is an ACCORD one; this lowers to ACKNOWLEDGE to track the further details. It also demonstrates again the marked/unmarked 'mm' contrast. Here, an elderly female patient recounts the worst of her experience in hospital.

P: I don't know how I was still alive actually

D: mm [rise-falling, longer] (4)

P: I was so exhausted

D: mm [low fall, shorter] (2)

P: because I didn't

=I was worried about xxx

D: =in fact I've just

I've just been reminded that we had you on **total** parenteral nutrition for a while
to get you **fit** for the operation (5)
didn't we?

P: mm mm

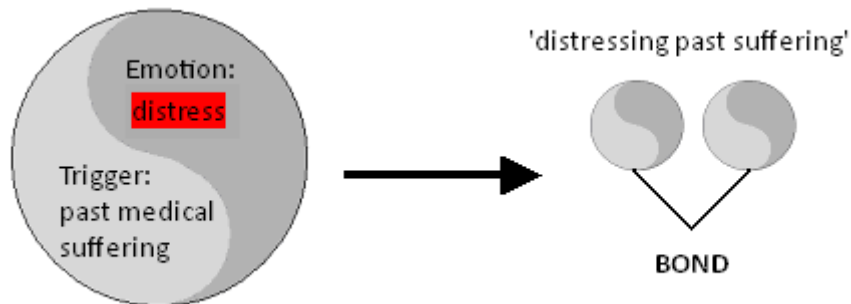


Fig 4.13: distress + past suffering construes a bond, communed around through the doctor's indirectly-validating ACCORD responses

The marked 'mm' with high pitch and rise-falling intonation contour conveys engagement with the patient's description of suffering, validating it and showing concern. This is followed by elaboration by the patient to which the doctor offers a less empathic response (unmarked 'mm'). He continues however to demonstrate his understanding, following up by reminding the patient of the extra treatment they had her on during this time. This validates her emotion and reconfirms the bond shared about her distressing previous illnesses (as shown in Figure 4.13). Figure 4.14 summarises the empathic contour of this exchange complex, which involves a fall from ACCORD to ACKNOWLEDGE to track elaboration, then a rise to VALIDATE to directly affirm understanding.

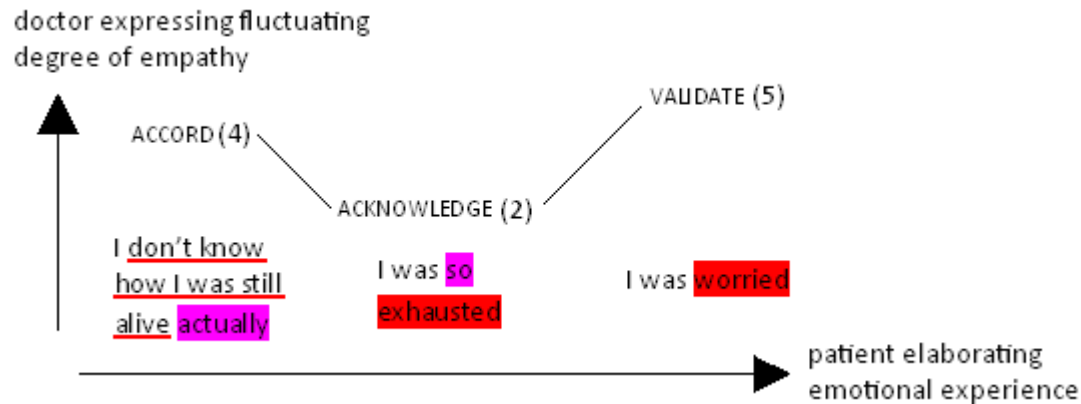


Fig 4.14: degree of empathy fluctuating as patient elaborates her distressing previous suffering

4.3 Summary: what are the 'ideal' doctor responses?

Chapter 4 has investigated the situations in which different response types are used, showing that varying levels of empathy can be appropriate in different situations and that there is no one ideal empathic response. When patients demonstrate concern, direct validation often seems most desirable (see section 4.2.1), although sometimes the indirect version (ACCORD) can be equally suitable (or even more, e.g. implying significant affiliation through 'the inability to express it in words': Gardner 2001:243). Although usually considered inappropriate, the SHARE response can sometimes be beneficial, allowing participants to bond through shared experience; however this is generally avoided to maintain professional distance (see 4.1.6). Level 1-3 responses also have a role to play in interpersonal communication: a lower level response can indeed be appropriate if used, for example, to track elaborations between stronger expressions (LISTEN/ACKNOWLEDGE), or to recognise values the doctor should not align with by neutrally acknowledging that the patient has shared them (ACKNOWLEDGE/SUPPORT). Even the deferral of proposed bonds can build rapport through 'laughing affiliation', by suspending a value participants cannot align with to defer to an implicated bond instead (see section 4.1.7). All of these responses also interact in empathic exchange complexes, developing overall communications of empathy over several turns as the emotions conveyed are clarified, emphasised or elaborated.

This chapter has examined the patterns in the use of the different response options. It has explored how doctors can use them to convey varying levels of empathy, and when the different levels may or may not be appropriate. In considering exchange complexes, it has analysed how use of differing responses can build to a high expression of empathy (the increasing empathic contour, see section 4.2.1), or decrease after a high expression has been given (the fluctuating contour, see section 4.2.2). It has also analysed situations where laughter is used to defer bonds when values are proposed around which the participants choose not to commune. This demonstrates that sometimes it seems the patient would rather not receive empathic understanding from the doctor but instead defer the bonding opportunity. All this supports the notion that there is no one correct response or response type that is most appropriate in responding to any empathic expression offered by the patient. Rather, different situations and expressions call for different sorts of support from the doctor: these are the patterns which this chapter has attempted to categorise.

Chapter 5: Conclusions, implications and further directions

This thesis has explored the language of clinical empathy in an attempt to broaden understanding of what constitutes effective communication in medicine. Targeted linguistic analysis of the ways in which doctors can demonstrate understanding of their patients' experiences and emotions was carried out to identify the different ways in which doctors can respond to patients' concerns and when each of these differing responses is appropriate. Chapter 3 introduced a new graded model of empathic responses, using linguistic criteria to categorise potential responses according to the degree of empathy conveyed. This drew on previous empathy frameworks, such as some of the medical models used in assessing empathic communication and one proposed model informed by APPRAISAL theory (each discussed in chapter 2). This research was based on a case study analysis of successful interpersonal skills, using recorded data from patient consultations with an expert empathic communicator. Following explanation of the proposed model, the contexts in which each of these responses were used were examined in chapter 4, which analysed the relationship between the level of empathy demonstrated and the circumstances in which it occurred – an overview sensitive to both ideational and attitudinal factors. This culminated in exploration of empathic contours, created over empathic exchange complexes. The notion of empathy developing over several conversational moves is not generally addressed in existing literature; this thesis has provided some insight into its significance in building affiliation.

5.1 Summary of findings

Different situations within the consultation and different expressions of emotion or opinion by patients call for different types of empathic response from doctors. There is not one 'ideal' way in which doctors should respond to patients' empathic opportunities; rather, effective responses depend on the nature, extent and explicitness of the concern expressed, and the negotiation of the interpersonal bond proposed, potentially over a series of exchanges.

Generally, direct validation through repetition, exclamation or verbs of understanding appears to be the most desirable response when patients present opportunities for affiliation; that said,

indirect validation (ACCORD) also appears to be sufficient. These assessments are based on this doctor's use of each response type and also on analysis of instances where patients' initial, more implicit expressions are met with lower level response types, and in which they accordingly pursue discussion of their concern until the empathic response they desire is given (e.g. Figure 5.1).



Fig 5.1: gradually increasing empathic contour as patient expresses emotion increasingly clearly (from Fig 4.9, see section 4.2.1)

As in previous findings (e.g. Bylund 2001; Ruusuvaori 2005), explicit sharing of patients' emotion is mostly avoided, presumably so that the doctor's professional, diagnostic position is maintained. However it can be used to provide comfort in situations where the emotion or experience being shared is sufficiently detached from the present issue of diagnosis and treatment and thus will not challenge the doctor's status as problem solver. For example, the doctor used the SHARE response to comfort a patient about an uncomfortable, embarrassing bowel procedure (see section 3.2.6): explaining how he has also had this experience and felt similar discomfort demonstrates a high level of understanding and support. Since the emotions conveyed relate to an external procedure and not, for instance, distress about the current condition, they do not affect his ability to give medical advice that the patient will respect.

Doctor-patient rapport can also be developed through Knight's (2010) system of 'laughing affiliation', where proposed values are 'laughed off' in favour of implicated bonds, around which the participants can indeed commune (see section 4.1.7). For example, laughing off the proposed trivialisation of surgery allows participants to commune around the implicated seriousness of the patient's medical issue:

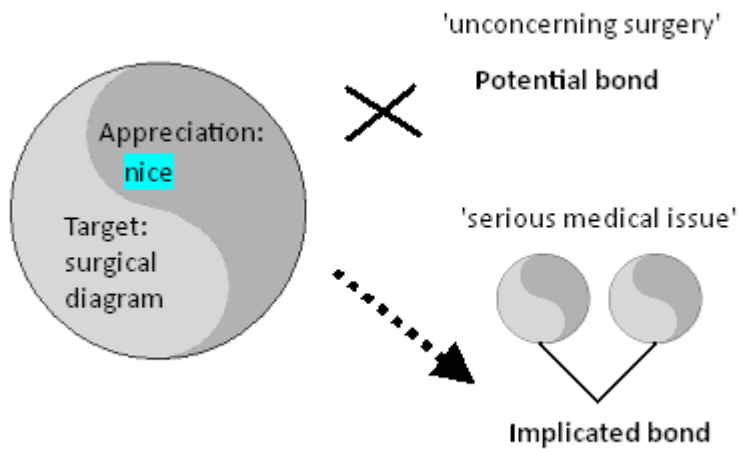


Fig 5.2: 'unconcerning surgery' bond is deferred; implicated 'serious medical issue' bond is deferred to (from section 3.3.1)

This has been shown to be an important aspect of consultation affiliation, as doctors should be careful not to defer bonds along with the patient if there is additional underlying concern that could be further expressed (see section 4.1.7). This strategy interacts with the other response options throughout the build-up of empathic exchange complexes. As discussed in chapter 4, all response types play a part in the development of empathic contours across complexes, and thus in the negotiation of affiliation.

5.2 Potential implications in medical education

This research addressed a continued need in the field of medical education for better training in interpersonal skills and communication. The importance of these skills to successful medical practice has long been established, and most medical schools do include communication training in their instruction (Cegala 2002). Yet there is still much societal criticism of doctors' inadequacies in this area and it is widely argued that there remains significant room for improvement (Levinson & Pizzo 2011). Researchers propose several reasons for this, such as inadequate time devoted to communication training or discontinuity of this training once

students enter the workforce (Levinson & Pizzo 2011). There is also the issue that some aspects of communication are difficult to define and therefore to teach, and the ability to demonstrate empathy is a skill that faces this problem (Buckman *et al.* 2011; Pounds 2011).

By exploring the language characteristics of examples of good empathic communication, the model introduced in this thesis targets this issue by proposing some systematic strategies for understanding clinical empathy. It suggests that there are linguistic correlates behind the spectrum of empathic response options doctors can use to engage with patient concerns, and that these language criteria can be used to identify, characterise and create empathic expressions.

For example, chapter 2 referred to the phrase *this is clearly worrying you*, used as an example of an 'empathic comment' (Gask & Usherwood 2002:1568). The paper in which this appears gives no further explanation of what makes it an 'empathic comment', implying a reliance on intuition; this has also been proposed as a barrier to improving competence (Buckman *et al.* 2011:570). However, by the model proposed, this response would clearly be classified as a high empathy, VALIDATE response due to the inscription of AFFECT which presumably echoes some 'worry' expressed by the patient. Another example mentioned is the statement *I understand how important it is for you to get back to work* (Segal 1995). This can also be accounted for as a VALIDATE response by its use of the direct statement of understanding. The proposed model also follows Sandvik *et al.*'s (2002) conversation analysis based criticism of the RIAS, by avoiding form/function distinction in identifying empathy. Analysing ATTITUDE instead, both *this is distressing for you* and *what bothers you the most?* (see section 2.3.2) can construe empathy as they inscribe AFFECT, and if used to follow a patient's expression of distress (or similar), both would classify as level 5 responses.

The function of back-channels such as *yeah* and *mm* has also been analysed to assess how they fit into the different levels of the model, from indicators of hearing to highly involved tokens of alignment. This work, informed by research of back-channel functions and further acoustic markers of emotional involvement (namely Gardner 2001), moves away from previous tendencies to group these responses with non-empathic ones (discussed in section 2.3.2) and instead explores how they too can help build affiliation. For example, *mm* with stressed, rise-

falling intonation and long duration can display significant engagement with concerns expressed by a patient and signal that his/her expression is valid. While not explicitly validating, a response like this implies similar legitimisation of the patient's worry and hence has been included in a category of indirect validation (ACCORD) below VALIDATE.

This thesis has also addressed the issue of identifying when patients are hinting at their concerns rather than stating them directly, since it is a demonstrated area in which doctors are missing opportunities to respond and thus build rapport. As discussed in chapter 2, many of the models used to assess doctors' empathy do not consider hinted concerns since they are difficult to define and frequently missed. However since this thesis targets training rather than assessment, it acknowledges the significance of including these expressions and proposes an APPRAISAL-based framework for identifying several of them. As defined in chapter 3, the criteria used include all instances of inscribed APPRAISAL plus some invoked attitudes. These include, for example, negative judgements of hospital staff invoked through description of contradictory and misleading instructions: 'cause some were saying no you don't need it and others were saying just have a light diet', and emotion invoked through descriptions of severe previous illness: 'I don't know how I was still alive actually'. This second instance also includes GRADUATION ('actually'), another criterion for identifying invoked attitude. It is true that such implicit attitudes, or indirect patient cues, can be difficult to identify and to define; while they cannot explain all these cues, the criteria proposed in this thesis aim to characterise a significant proportion. Approaching this issue with this APPRAISAL-based framework could thus enable medical educators to teach doctors some precise language features to look for in recognising hinted concerns.

Another contribution made here is the analysis of empathic exchange complexes and the contours that develop across them. This allows further understanding of how empathy can be expressed gradually (e.g. Sandvik *et al.* 2002:240) and develop over a sequence of exchanges. It explains that less empathic responses can also play a part in the negotiation of affiliation, when combined with more engaged expressions. If added to the existing literature and training material, these findings could help develop understanding of the language that construes empathy and thus assist in teaching physicians how to communicate more effectively.

5.3 Potential implications in linguistics

Beyond its insight into the field of medical communication training, the research undertaken here also provides development of the theories of affiliation that inform its findings. Applying bonding theory to analysis of interpersonal communication in the consultation extends the existing work to examine bonding in a professional medical context. It provides examples of bonding in action: how it can be used to promote positive relationships between the doctor and the patient in the consultation. It also applies Knight's theory of laughing affiliation (2010) to explore how participants can continue to build affiliation through deferring potential bonds when they cannot commune around them. This seems to be an important aspect of rapport building, as several evaluative couplings proposed by patients or kin are laughed off before any response is given, for various reasons such as not wanting to commune around negative judgements or trivialisations of the illness. Knight's theory is therefore supported by the data and analysis here, which likewise suggest that laughing affiliation is another mechanism through which relationships can develop.

It also suggests that bonding can be achieved with different degrees of strength, in correlation with the levels of empathic responses presented in the model. That is, this thesis separates bond acceptance into levels of intensity and explicitness, where expressions of greater degrees of empathy confirm the bond more emphatically than less direct expressions, as in the contrast between VALIDATE and ACCORD responses. Beyond both of these responses is the SHARE option, arguably an even stronger bond acceptance as the proposed value is not only accepted but explicitly shared. In a professional context such as medicine, it is suggested that bonding can be achieved not only through explicit sharing of evaluative couplings, but also through direct and indirect validation.

The tenor of the consultation is different to casual conversation, as one participant is at a significantly higher power and knowledge status, and all participants wish to sustain this power imbalance. It is thus actually far more common for bonding to occur through validation of the patient's perspective than through shared experiences. Were the doctor to share emotions such as fear or worry, it would be harder to resume the position of medical authority and provide a

solution. It would not reassure the patient to know the doctor shared his/her sufferings instead of being able to resolve them. In addition, due to its focus on the need for improvement in identifying and responding to patients' concerns, this study only examined instances of patient-initiated bonding. Further insight into the nature of consultation affiliation could be gained in analysis of bonds proposed by the doctor, particularly when eliciting patient's concerns. Application of bonding theory to the medical consultation reveals the influence of interesting dimensions of the consultation tenor, and develops understanding of how affiliation can function in professional contexts.

Lastly, this research has examined how intonation can be used in identifying affiliation, extending analysis to include acoustic properties of speech. This builds on language-based affiliation analysis in a similar way to Martin *et al.* (in press) who considered paralinguistic body language factors in the analysis of bond negotiation and identity in youth justice conferences. As will be discussed in the following section, there are many paralinguistic features that can affect interpersonal communication, and these ought to be addressed in consideration of successful rapport building. This thesis has made some further advances in contributing language-external features to discussion of bonding and affiliation by examining how acoustic evidence, namely intonation contours, can support the identification of bond acceptance in minimal or non-lexical responses.

5.4 Future directions

Some of the major areas for future development of this work are in the importance of paralinguistic features such as facial expressions and body language, further cues for identifying hinted concerns, and the ways in which doctors can initiate bonding opportunities by eliciting patients' emotions. There is also the need to assess the impact of cultural differences; this study's findings do not claim to be representative of successful empathic communication for all cultures, yet in a multicultural society it is increasingly important to understand different perspectives in cross-cultural interaction.

It would be beneficial to discover how paralinguistic systems of meaning interact with the language in the negotiation of bonds and in the communication of empathy. Time and ethical requirements limited the data in this research to audio recordings, however further analysis using video data would provide additional insight into the simultaneous paralinguistic systems that are at play in interpersonal communication. It seems that these systems face similar problems with limited understanding and definition of what, for example, an 'empathic gesture' is (FHCS: Frankel & Stein 1999), and therefore modelling them using a systematic framework could also enhance medical communication training (e.g. Zappavigna *et al.*'s (2008) model of body language could be used to continue this analysis in terms of SFL and bonding). Also, further to the prosodic information used to analyse back-channels in this thesis, continued research into 'interactional markings of relevance' such as changing volume or speech patterns, hesitation or metaphors (Sator *et al.* 2008) would assist in building a framework for teaching doctors how to identify the hinted concerns that are still often missed.

It could also be worth considering the impact of the ENGAGEMENT system within APPRAISAL analysis, to further explore how patients present concerns and how this could help doctors identify them. For example, one patient uses projection ('[other Dr.] thought') and modality ('sort of', 'very unlikely') when stating how his other doctor 'sort of thought it'd be very unlikely to get another attack'. Although no attitude is inscribed, the use of heteroglossia might be linked to invoked concerns underlying descriptions of medical issues (here, 'attack') or pain. There is certainly room for investigation of evaluation and emotion in relation to pain. Since this is a medical context, pain is a prominent element of the field, and so the problem arises as to when descriptions of pain can be classed as invoking AFFECT and when they are just part of the ideational content. In this thesis, pain was interpreted to invoke AFFECT when it was presented with inscriptions of GRADUATION or of other forms of ATTITUDE. Yet it would be beneficial to explore further the implications behind expressions of, for instance, 'shooting pain', 'stabbing pain', 'a fair bit of pain' and 'crippling pain' (all examples from the consultation data; see Halliday 1998 for more on the grammatical complexity of pain).

Finally, this study has only analysed one successful empathic communicator, and has drawn on literature predominantly from Australian, American and Western European medical communities. Wider analysis of a larger number of model communicators would enable a more

comprehensive model to be established. Further, it is well known that perceptions of politeness and appropriateness differ significantly across cultures (e.g. Spencer-Oatey 2008), and so the correlation between language strategies and good communication skills described in this thesis is only intended to apply to the communities in which it has based its research. Even within this subset there is evidence of variation, such as between American and Australian English uses of the *right* back-channel (see chapter 3.2.2). This prompts the interesting issue of how to succeed when the participants in the consultation are from different cultural backgrounds and thus may have different perceptions and expectations for the consultation, which certainly should be further explored if effective communication and interpersonal skills are to be maximised in medicine.

References

- Adelswärd, V. (1989). Laughter and dialogue: the social significance of laughter in institutional discourse. *Nordic Journal of Linguistics* 12: 107-136.
- Alasuutari, M. (2009). What is so funny about children? Laughter in parent-practitioner interaction. *International Journal of Early Years Education* 17(2): 105-118.
- Beach, W. (1995). Preserving and constraining options: 'okays' and 'official' priorities in medical interviews. In Morris, G.H. and Cheneil, R. (Eds.) *Talk of the clinic: exploration in the analysis of medical and therapeutic discourse*. Hillsdale: Lawrence Erlbaum. 259-289.
- Bernstein, B. (1990). *The structuring of the pedagogic discourse: Class, codes and control*. London: Routledge.
- Bird, J. and Cohen-Cole, S.A. (1990). The three-function model of the medical interview. An educational device. *Advances in Psychosomatic Medicine* 20: 65-88.
- Boersma, P. and Weenink, D. (2011). Praat: doing phonetics by computer [Computer program]. Version 5.2.21, retrieved 11 April 2011 from <http://www.praat.org/>
- Branch, W.T. and Malik, T.K. (1993). Using windows of opportunities in brief interviews to understand patients' concerns. *Journal of the American Medical Association* 169: 1667-1668
- Britten, N., Stevenson, F., Barry, C., Barber, N. and Bradley, C. (2000). Misunderstandings in prescribing decisions in general practice: qualitative study. *British Medical Journal* 320: 484-488.
- Buckman, R., Tulskey, J. and Rodin, G. (2011). Empathic responses in clinical practice: Intuition or tuition? *Canadian Medical Association Journal* 183(5): 569-571.
- Bylund, C. (2001). Empathic communication in the physician-patient encounter. Unpublished PhD thesis. North-Western University. Evanston.
- Bylund, C. and Makoul, G. (2002). Empathic communication and gender in the physician-patient encounter. *Patient Education and Counseling* 48: 207-216.
- Cegala, D. and Broz, L. (2002). Physician communication skills training: a review of theoretical backgrounds, objectives and skills. *Medical Education* 36: 1004-1006.
- Clay, M. (1984). Development of an empathic interaction skills schedule in a nursing context. *Journal of Advanced Nursing* 9: 343-350.
- Cook, R., Render, M. and Woods, D. (2000). Gaps in the continuity of care and progress on patient safety. *British Medical Journal* 320(7237): 791-794.
- Cruttenden, A. (1986). *Intonation*. Cambridge: Cambridge University Press.

- Edwards, A. and Elwyn, G. (2001). Understanding risk and lessons for clinical risk communication about treatment preferences. *Quality Health Care* 10(Suppl 1): i9–i13.
- Epstein, R., Hadee, T., Carroll, J., Meldrum, S., Lardner, J. and Shields, C. (2007). “Could this be something serious?” Reassurance, uncertainty, and empathy in response to patients’ expressions of worry. *Journal of General Internal Medicine* 22(12): 1731-1739.
- Finset, A. (2010). Emotions, narratives and empathy in clinical communication. *International Journal of Integrated Care* 10(Suppl): e020.
- Frankel, R. and Stein, T. (1999). Getting the most out of the clinical encounter: the four habits model. *The Permanente Journal* 3(3):79-88.
- Gardner, R. (2001). *When listeners talk*. Amsterdam: Benjamins.
- Gardner, R. (2005). Acknowledging strong ties between utterances in talk: Connections through right as a response token. In Mushin, I. (Ed). *Proceedings of the 2004 conference of the Australian Linguistics society*.
- Gask, L. and Usherwood, T. (2002). ABC of psychological medicine: the consultation. *British Medical Journal* 324: 1567-1569.
- Haakana, M. (1999). Laughing matters. A conversation analytical study of laughter in doctor-patient interaction. Unpublished PhD thesis. University of Helsinki. Helsinki.
- Haakana, M. (2001). Laughter as a patient's resource: dealing with delicate aspects of medical interaction. *Text* 21(1/2): 187-219.
- Halliday, M.A.K. (1978). *Language as a social semiotic: the social interpretation of language and meaning*. London: Edward Arnold.
- Halliday, M.A.K. (1998). On the grammar of pain. *Functions of Language* 5(1): 1-32.
- Halliday, M.A.K. (2004/1994). *An introduction to functional grammar*. London:Edward Arnold. (2004 third edition revised by C.M.I.M. Matthiessen).
- Hood, S. and Martin, J.R. (2006). Invoking attitude: the play of graduation in appraising discourse. *Continuing discourse on language - a functional perspective*. Equinox, London. 2: 737-762.
- Ihler, E. (2003). Patient-physician communication. *Journal of the American Medical Association* 289(1): 92.
- Institute of Medicine. (2001). *Crossing the quality chasm: a new health system for the 21st century*. Washington, D.C.: National Academy Press.

- Ishikawa, H., Hashimoto, H., Roter, D.L., Yamazaki, Y., Takayama, T. and Yano, E. (2005). Patient contribution to the medical dialogue and perceived patient-centeredness. An observational study in Japanese geriatric consultations. *Journal of General Internal Medicine* 20(10): 906-910.
- Kim, S.S., Kaplowitz, S. and Johnston, M. (2004). The effects of physician empathy on patient satisfaction and compliance. *Evaluation and the Health Professions* 27(3): 237-251.
- Knight, N. (2010). Laughing our bonds off: conversational humour in relation to affiliation. Unpublished PhD thesis. University of Sydney. Sydney.
- Lambertz, K. (2011). Back-channelling: the use of yeah and mm to portray engaged listenership. *Griffith Working Papers in Pragmatics and Intercultural Communication* 4(1/2): 11-18.
- Levinson, W., Gorawara-Bhat, R. and Lamb, J. (2000). A study of patient clues and physician responses in primary care and surgical settings. *Journal of the American Medical Association* 248(8): 1021-1027.
- Levinson, W. and Pizzo, P.A. (2011). Patient-physician communication: it's about time. *Journal of the American Medical Association* 305(17): 1802-1803.
- Little, P., Everitt, H., Williamson, I., Warner, G., Moore, M., Gould, C., Ferrier, K. and Payne, S. (2001). Preferences of patients for patient centred approach to consultation in primary care: observational study. *British Medical Journal* 322: 468-472.
- Martin, J.R. (1992). *English text: systems and structure*. Amsterdam: Benjamins.
- Martin, J.R. (1996). Evaluating disruption: symbolising theme in junior secondary narrative. In Hasan, R. and Williams, G. (Eds.) *Literacy in Society*. Harlow, U.K: Addison Wesley Longman.
- Martin, J.R. (2004). Mourning: how we get aligned. *Discourse and Society*, 15(2-3): 321-344.
- Martin, J.R. (2008). Intermodal reconciliation: mates in arms. In L. Unsworth (Ed.) *New literacies and the English curriculum: multimodal perspectives*. London: Continuum. 112-148.
- Martin, J.R. and Stenglin, M.K. (2007). Materialising Reconciliation: negotiating difference in a transcolonial exhibition. *New directions in the analysis of multimodal discourse*. Lawrence Erlbaum Associates: Mahwah. 215-238
- Martin, J.R. and Rose, D. (2007). *Working with discourse: meaning beyond the clause*. London: Continuum.
- Martin, J.R. and White, P.R.R. (2005). *The language of evaluation: appraisal in English*. London: Palgrave.
- Martin, J.R., Zappavigna, M., Cleirigh, C. and Dwyer, P. (in press). Users in uses of language: embodied identity in Youth Justice Conferencing. *Text and Talk*.

- Mercer, S.W., Maxwell, M., Heaney D. and Watt, G.C.M. (2004). The consultation and relational (care) measure: development and preliminary validation and reliability of an empathy-based consultation process measure. *Family Practice* 21(6): 699-705.
- Neumann, M., Bensing, J., Mercer, S., Ernstmann, N., Ommen, O. and Pfaff, H. (2009). Analyzing the “nature” and “specific effectiveness” of clinical empathy: a theoretical overview and contribution towards a theory-based research agenda. *Patient Education and Counseling* 74: 339-46.
- O’Keefe, M. (2001). Should parents assess the interpersonal skills of doctors who treat their children? A literature review. *Journal of Paediatric and Child Health* 37: 531-538.
- Pounds, G. (2011). Empathy as ‘appraisal’: a new language-based approach to the exploration of clinical empathy. *Journal of Applied Linguistics and Professional Practice* 7(2): 139-162.
- Roter, D.L. and Larson, S. (2001). The relationship between residents’ and attending physicians’ communication during primary care visits: an illustrative use of the Roter Interaction Analysis System (RIAS). *Journal of Health Communication* 13: 33-48.
- Ruusuvuori, J. (2005). “Empathy” and “sympathy” in action: attending to patients’ troubles in Finnish homeopathic and general practice consultations. *Social Psychology Quarterly* 68(3): 204-222.
- Ruusuvuori, J. (2007). Managing affect: integration of empathy and problem-solving in health care encounters. *Discourse Studies* 9(5): 597-622.
- Sacks, H. (1992). *Lectures on Conversation, 2 vols.* Oxford: Basil Blackwell.
- Sandvik, M., Eide, H., Lind, M., Graugaard, P.K., Torper, J. and Finset, A. (2002). Analyzing medical dialogues: strength and weakness of Roter’s interaction analysis system (RIAS). *Patient Education and Counseling* 46(4): 235-241.
- Sator, M., Gstettner, A. and Hladschik-Kermer, B. (2008). Doctor-patient-communication in an oncological outpatient department. A linguistic study of communication problems. *Wien Klin Wochenschr: The Middle European Journal of Medicine* 120(5-6): 158–170.
- Segal, E.S. (1995). Maintaining communication in a time of uncertainty. *Archives of Family Medicine* 4: 1066-1067.
- Selting, M. (1994). Emphatic speech style – with special focus on the prosodic signaling of heightened emotive involvement in conversations. *Journal of Pragmatics* 22: 375-408.
- Slade, D., Scheeres, H., Manidis, M., Iedema, R., Dunston, R., Stein-Parbury, J., Matthiessen, C., Herke, M. and McGregor, J. (2008). Emergency communication: the discursive challenges facing emergency clinicians and patients in hospital emergency departments. *Discourse and Communication* 2(3): 271-298.

- Spencer-Oatey, H. (2008). *Culturally speaking: culture, communication and politeness theory 2nd ed.* London: Continuum.
- Sperry, J.A. (2008). Patient care in everything we do series. *Patient talk 101: tips for effective and efficient patient communication* [lecture]. November 20. West Virginia: WVU Health Sciences Center.
- Stenglin, M.K. (2004). Packaging curiosities: towards a grammar of three-dimensional space. Unpublished PhD Thesis. University of Sydney. Sydney.
- Suchman, A.L., Markakis, K., Beckman, H.B and Frankel, R. (1997). A model of empathic communication in the medical interview. *Journal of the American Medical Association* 277: 678-682.
- Tannen, D. (1984). *Conversational style.* Norwood: Ablex.
- Tebble, H. (1999). The tenor of consultant physicians. *The Translator* 5(2): 179-200.
- Truax, C.B. and Carkhuff, R.R. (1967). *Toward effective counseling and psychotherapy: training and practice.* Chicago, IL: Aldine Publishing Company.
- Ward, N. (2006). Non-lexical conversational sounds in American English. *Pragmatics and Cognition* 14(1): 113-184.
- West, C. (1984). *Routine complications: troubles with talk between doctors and patients.* Bloomington: Indiana University Press.
- Woodward-Kron, R., Flynn, E., Bow, C., Pill, J., Fraser, C., Stevens, M., Pryor, L. and Maxwell, O. (2001) *Doctors speak up: communication and language skills for international medical graduates,* [Online]. Available: <http://doctorsspeakup.com>. [November 2012].
- Wright, E.B., Holcombe, C. and Salmon, P. (2004). Doctors' communication of trust, care, and respect in breast cancer: qualitative study. *British Medical Journal* 328: 864-867.
- Zappavigna, M., Dwyer, P. and Martin, J.R. (2008). Syndromes of meaning: exploring patterned coupling in a NSW Youth Justice Conference. In A. Mahboob, and K. Knight (Eds.) *Questioning Linguistics.* Newcastle: Cambridge Scholars Publishing. 164-185.

Appendix: Recognition of external ethics approval (CHAMP project, Macquarie University)



RESEARCH INTEGRITY
Human Research Ethics Committee
Web: http://sydney.edu.au/research_support/ethics/human/
Email: ro.humanethics@sydney.edu.au
Address for all correspondence:
Level 6, Jane Foss Russell Building - G02
The University of Sydney
NSW 2006 AUSTRALIA

IM/KR

27 June 2012

Professor James Martin
Department of Linguistics
School of Letters, Art and Media
The University of Sydney
Email: james.martin@sydney.edu.au

Dear Professor Martin

Title: Communication for Health and Medical Professionals [Protocol No. 15046]

Honours Student: Ms Olivia Watson

The Executive of the Human Research Ethics Committee (HREC) has reviewed your study to include the Honours student – Ms Olivia Watson and acknowledges your right to proceed under the authority of Macquarie University Human Research Ethics Committee.

The Human Research Ethics Committee advises that you consult with The University of Sydney **Audit and Risk Management Office** (http://sydney.edu.au/audit_risk/) to ensure that University of Sydney staff/students and premises are adequately covered for the purpose of conducting this research project.

Any modifications to the study must be approved by Macquarie University Human Research Ethics Committee. A copy of the approved modification, approved progress report and any new approved documents must be provided to The University of Sydney HREC for our records.

Please do not hesitate to contact Research Integrity (Human Ethics) should you require further information or clarification.

Yours sincerely

A handwritten signature in black ink, appearing to read 'I Maxwell'.

Associate Professor Ian Maxwell
Chair
Human Research Ethics Committee

cc Ms Olivia Watson [Email: owat5377@uni.sydney.edu.au]

Associate Professor Lynda Yates [Email: lynda.yates@mq.edu.au]

Manager Human Ethics
Dr Margaret Faedo
T: +61 2 8627 8176
E: margaret.faedo@sydney.edu.au

Human Ethics Secretariat:
Ms Karen Greer T: +61 2 8627 8171 E: karen.greer@sydney.edu.au
Ms Patricia Engelmann T: +61 2 8627 8172 E: patricia.engelmann@sydney.edu.au
Ms Kala Retnam T: +61 2 8627 8173 E: kala.retnam@sydney.edu.au

ABN 15 211 513 464
CRICOS 00026A