Keeping 'small talk' small in healthcare encounters: negotiating the boundaries between on- and off-task talk.

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Abstract

Healthcare interactions often involve social, relational, small-talk or 'off-task' sequences which are largely topically distinct from the institutional business of the setting. In this paper we examine data from pre-operative assessment sessions in a Scottish hospital in order to explore the transitions between on- and off-task talk. In the majority of instances the movement between social and medical talk is routine and unproblematic, and both nurse and patient orient to the boundaried nature of off-topic talk. However, occasionally patients' social talk evolves into personal disclosure and troubles telling which may disrupt the institutional agenda and which can lead to difficulties in the negotiation of sequence closure. Data are in British English.

Patients and staff sometimes engage in off-task or 'social' talk in healthcare interactions. Indeed this might even be encouraged by the staff, as part of 'patient-centred medicine' (a term first introduced as a term by Balint et al (1970)) so as to promote patient participation and allow the 'voice of the lifeworld' to coexist with the 'biomedical' perspective (Mishler 1984 ; Stewart et al, 1995, Barry et al (2001)). In interactional terms, this may involve putting the patient at ease through: empathy, the conveyance of interest, a non-judgemental attitude and humour (McCreaddie and Wiggins 2008); friendliness, empathic and reflective listening and encouragement, and a general social orientation (Ong et al 1995). Small talk may also be clinically relevant, as Ragan (2000) argues in a study of humour and self-disclosure in a sample of women's health encounters.

But small talk, however 'patient-centred' may also come into conflict with the aims of the interaction under way, and require the health practitioner to take steps to return to a more formal agenda. Pre-operative assessments are an interactional site in which small talk sequences are likely to occur and give rise to such problems. That is the site of the study reported in this article.

The pre-operative assessment

The focus of the pre-operative assessment is to provide information, assess risk, review co-existing illnesses and treatment and plan for high risk patients. In the NHS up until the late 1980s healthy patients were routinely admitted to surgical wards the day prior to their planned surgery. However, from the 1990s onwards, the advent of pre-operative assessments became increasingly common place due to the re-organisation of the NHS and in the increase in Day Surgery procedures (Smith et al 2011). Nurses in extended roles working in tandem with anaesthetists undertake pre-operative assessments on patients up to four weeks prior to their elective procedures: minor day surgery or major in-patient operations.

The pre-operative assessment involves a medical examination and assessment of the patient's suitability to receive an anaesthetic, a week or so prior to an operation and take the form of a series of questions about the history of their health (especially previous surgery), information gathering about current medication and conditions, and a number of routine procedures such as taking blood pressure and ECGs. The assessments are conducted by nurses whose talk has been studied less than doctors (Iedema 2007; Jones 2003), but whose interactions previous research has suggested (in comparison to doctors') are less hierarchical, formal and institutional (Jones 2007; Candlin 2000), more 'affective' and socially-oriented (Fisher 1991; Ong et al 1995) and more likely to involve humour (Grainger 2002, McCreaddie and Wiggins 2008, Mallet and A'hern 1996) which has been shown to generate greater patient satisfaction (McCreaddie and Payne, 2012).

The 'checklist' of health-related questions which must be completed for each patient and the non-verbal procedures being performed on the patient by the nurse are both quite clearly demarcated and routinised 'on-task' activities and provide a contrast with 'small talk' sequences which occur alongside or within them. History taking sequences and their constraints for participants have been well documented in the CA literature (e.g. Heritage and Sorjonen 1994, Stivers & Heritage 2001, Heritage 2010), and it is in such sequences that we observe small talk emerging, often 'stepwise',

from health-related information provided by the patient. We also focus on the discrete small talk that emerges (usually nurse-initiated) during non-verbal procedures, argued by Maynard and Hudak (2008: 9) to be a form of disattention and detachment from the bodily encounter (see also Heath 1986). Forms of small or social talk thus embody a range of functions in medical encounters which can be broadly termed 'patient-centred'. In our analysis we pay particular attention to the way in which participants orient to the transitions between social and medical talk and negotiate sequence closure. Whilst a return from small talk to the medical task is usually unproblematic, occasional expansions of 'small talk' into troubles-telling (by the patient) can lead to more troubled and 'messy' negotiations of closure.

Defining off-task/social/relational/small talk

Social or relational talk plays an important role in medical encounters and its embeddedness in the interaction is actively prescribed by a number of researchers (Fisher 1991; Mishler 1984; Barry et al 2001). The more discrete category of 'small talk' is also social in nature, first identified by Malinowski as a form of action 'serving to establish bonds of personal union between people' (Malinowski 1972[1923]: 151). An assumption in theorisations of small talk is that there is a distinction to be made between social/relational talk and small talk, the latter having connotations of peripherality, inconsequentiality and transience, 'undemanding in terms of topic and intellectual content' (Holmes 2000: 50).

A number of functions have been ascribed to 'small' talk in institutional settings: 'propitiatory' silence-filling (Laver, 1975; Holmes 2000) sometimes whilst non-verbal tasks are performed (McCarthy 2000), putting the patient at ease and lessening the hierarchical distance between participants (Ragan 2000), disattending to the institutional goals (Maynard and Hudak 2008) and moving to the closure of interactions (Jefferson 1988; Hudak and Maynard 2011) many of which are seen to be inextricably connected to the successful accomplishment of the institutional agenda. The intermittent and often superficial nature of small talk in the kinds of non-verbal sequences examined below may lead us to classify this as a 'continuing state of incipient talk' (Schegloff and Sacks 1973) whose sequences do not demand distinct closure and where lapses between topically linked sequences are permitted.

For many researchers, small talk is assumed to be distinct, or a departure from, the institutional agenda. McCarthy (2000) for instance, distinguishes between 'transactional' and 'relational' talk; Coupland and Ylänne-McEwan (2000) argue that 'interstitial small talk involves suspension from institutional roles' (169); Hudak and Maynard (2011) define small talk as 'a line of talk which is referentially independent from institutional identities as patients and surgeons' (634), and Stokoe (2000) argues, in her study of the achievement of topicality in university seminars, that students explicitly orient to the 'off-task' (and in this setting, 'illicit') nature of such non-task-based talk (see Thornborrow (2003) for similar observations). In other words, this distinction between on- and off-task is shown to be meaningful to the students (rather than a distinction imposed by the analyst).

However, whilst small talk in institutional settings might be thought to be necessarily defined as 'off-task', a number of researchers have argued for the porous nature of the boundaries between on- and off-task sequences, particularly in contemporary service

encounters which are increasingly 'conversationalised' (Fairclough 1994). Coupland, for instance claims that 'defining small talk too rigidly as a bounded mode of talk will constrain the analysis of its social function' (Coupland 2000: 13) and in Ragan's analysis of women's health care encounters with nurses, 'so-called task and relational goals in these contexts are inextricably enmeshed' (Ragan 2000: 269). In part, this recognition of the institutional relevance of small talk sequences is linked to the broader, phatic functions of small talk as easing social relations or 'doing' collegiality in the context of the interaction as a whole, so that 'so-called "small talk" in the context of …healthcare situations is pivotal to the achievement of instrumental, i.e. medical goals' (Ragan 2000: 269[1]). In another sense, the bounded, structural distinction between on- and off-task may be blurred when social talk 'bleeds' into the institutional agenda. McCarthy (2000) for instance identifies a category of talk he describes as 'transactional-plus-relational' (p104) (e.g. non-obligatory task evaluations, noticings), and Hudak and Maynard (2011: 635) argue that a 'simple on-off- task distinction is not always clear because some talk appears to be both on- and off-task at the same time' . They go on to identify a category of 'co-topical small talk' which is instrumentally related to on-going medical talk whilst performing other actions – e.g. non-serious comments occasioned by something in the on-task work (Hudak and Maynard 2011: 645).

In the analysis of our own data, we also observe the enmeshed quality of social and institutional talk: small, relational and social talk makes an appearance in medical exchanges, and conversely, medical concerns emerge in small talk sequences in the form of 'troubles telling'. However, we also observe that these types of sequences (small talk, troubles telling, on-task talk) are frequently *constructed* as discrete and are oriented to as such by the way in which the boundaries between the two types of talk are explicitly negotiated.

Gail Jefferson first identified the phenomenon of 'troubles telling' in a series of papers arising from a funded research project she undertook with John Lee in 1980 (Jefferson and Lee 1981, Jefferson 1984a, 1984b, 1988). 'Troubles telling' is a particular kind of conversational sequence which involves personal disclosure, complaint/moaning, revelation of difficult, dramatic, intimate or embarrassing episodes or discussion of problems. Troubles telling tends to be followed by affiliation or expression of empathy which then prompts 'emotionally heightened' talk, and Jefferson 1984b has suggested that 'troubles receptiveness' is the 'job' of the recipient (351): 'Troubles recipients routinely provide reassurances' (363). In the context of the pre-operative assessment, troubles recipiency may come into conflict with the institutional agenda. So whilst these off-task sequences usually do little to disturb or alter the institutionally-defined, formulaic sequences in the pre-operative assessment procedure, where they do threaten it, conversational work is needed, particularly by the healthcare provider, to regulate the boundaries.

In our own data we often see relational talk developing out of small talk, but crucially what we also see is the emergence of an interactional order in which small talk is generally kept 'small' and relatively inconsequential. In the analysis that follows, we explore the conversational work that occurs at boundaries between on- and off-task

[1] see also Komter 1991, Ylänne-McEwan 1997, McCreaddie 2010 for studies that point to the importance of 'small' talk for the goals of the institutional talk.

sequences, as well as the interactional consequences of personal disclosure and 'troubles-telling' (Jefferson 1984a, 1984b, 1988) that emerge in small talk sequences, and which threaten the 'smallness' and 'bracketability' of the category of small or social talk.

Data and Methods

The data used in this study comprise pre-operative assessment sessions with three different nurses and were audio-recorded[2] from an NHS hospital in Scotland over a period of a day. Ethical permission to audio record and transcribe these sequences were obtained from the NHS ethics board and informed consent was secured from all participants in advance (via letter). Anonymity for all participants (including individuals discussed within the conversations) was assured by the alteration of key, potentially identifying details of names and locations. The digital recording equipment[3] was left with the nursing staff to record their own sessions (in line with the ethics agreement) and they were responsible for checking consent again with patients before the session commenced.

The data are analysed using conversation analysis which prioritises the social and cultural understandings of members as they are revealed in everyday talk (e.g. Sacks 1984). This methodical uncovering of members' methods is approached by analysing interactions as they unfold sequentially so that a sense of the *indexicality* (i.e. prior conversational context and consequences) of particular conversational moves can be appreciated (Schegloff 1997). This is particularly relevant in an analysis of the normative order of particular kinds of sequences or genres of talk and the negotiation of transitions between them, and some of the sequential concerns of CA (such as preference organisation, the uptake of turns, pursuit of response and patterns of (dis)affiliation) will be shown to be particularly relevant to our data.

The placement and responsibility for on- and off- task sequences

Within our corpus of data there are a number of places where social, off-task talk tends to occur. Most commonly, we find it occurring in two places: firstly, during the non-verbal proceudres where e.g. measurements and blood samples are taken and secondly, within the information gathering sequence. Small talk may be initiated by the nurse or patient, but a return to the institutional task is almost always initiated by the nurse.

Nurse-initiated small talk

Off-task, small talk sequences within non-verbal procedures are more commonly initiated by the nurse, and curtailed by a transition into on-task talk.

In this first extract the nurse has just completed the ECG, and is now tidying up the ECG equipment i.e. taking the leads off the patient's chest, cleaning off the gel and re-packing the ECG. She initiates a small talk sequence during this non-verbal

[2] The NHS Ethics board would not allow us to video-record data.

[3] Nurses wore lapel microphones with the recorders fastened to their pockets meaning that they could move around and still be heard on the recordings.

activity. Following the conclusion of this sequence she then goes on to ascultate his chest (to check for chest infection) at which point the social talk sequence is curtailed.

Extract 1: PA. A1

1	Nurse:	so did you have good ↑↑weather then? when yer were away?
2	Patient:	aye it was good aye (the weather though but)
3	Nurse:	↑what were yer over for?
4	Patient:	jus ma pal's birthday weekend=
5	Nurse:	=was it
6	Patient:	aye
7	(0.8)	
8	Nurse:	↑very ↓good
9	(1.8)	
10	Patient:	done it for the last couple of years
11	(0.2)	
12	Nurse:	↑have you?
13	Patient:	aye (.) cos we're all about the same age and (.) err (0.8) we
14		do a thing like this is your ↑life ( )
15	Nurse:	((sneeze)) ↑very good
16	Patient:	it's a good laugh
17	(1.2)	
18	Nurse:	oh excuse me (.) right that's ↓you
19	Patient:	oh right yes that's fine thank you
20	Patient	((yawns))
21	Nurse:	maybe you can get home (get) a couple of hours sleep
22		(2.0) before you got ta work
23	Patient:	yeah
24	(2.4)	
25	Nurse:	err: now (.) what ah was going to do=don't put your
26		shirt on cos (I'm) gonna get ma
27		stethoscope and we'll just have a listen to yer (.) lungs

In this sequence the nurse reinitiates an earlier topic that had been introduced during the opening sequence of the whole assessment: the patient's recent holiday. Small talk/off-task/social talk is an almost obligatory presence in pre-op assessments, where non-verbal, bodily activities involve otherwise long and potentially awkward silences (McCarthy 2000) and where small talk is a way of 'disattending …embodied conduct' (Maynard and Hudak 2008: 667). Small talk in this extract is a collaborative form of silence filling and distraction from the bodily contact, and both participants also collaborate on sequence closure as the non-verbal activity (cleaning up the ECG equipment) draws to an end. On lines 8 and 15 the nurse provides an assesssment of aspects of the patient's holiday 'very good'. Generalised assessments such as these have been observed by Schegloff to function as "sequence closing thirds" (Schegloff, 2007, p. 123) though the first instance is not oriented to as such by the patient, who extends the sequence. However, on line 15, the 'very good' and its close-relevance is oriented to by the patient's own generalised assessment on line16 : 'it's a good laugh' and after apologising for her sneeze ('oh excuse me') the nurse then explicitly orients to the completion of this non-verbal activity 'right that's you' which shows she has (temporarily) finished with the patient's body and is 'returning' it to him, with the discourse marker 'right' indexing a transition between sequences. The nurse briefly reinitiates social talk in response to the patient yawning 'maybe you can get home get

a couple of hours sleep' before returning to the medical task of listening to the patient's chest.

The transition to on-task talk here and in other examples is relatively disjunctive (Jefferson 1984a) representing a shift of footing associated with the completion of a medical task, but the transition is flagged explicitly by the nurse: 'right that's you', and treated as unproblematic by the patients in our study.

Patient-initiated social talk

A second type of social sequence is usually initiated by the patient and most often occurs in step-wise transition (Jefferson 1984a) where a social topic develops out of a response given by the patient and tends to be personal in nature (e.g. further medical disclosure, information about family). Whilst these social sequences are often initiated by the patient in the form of bids or proffers, such as topic-initial utterances or mentionables (see also Hudak and Maynard 2011: 638), they are not always taken up or developed by the nurse. In the first sequence the nurse is gathering information via a series of formulaic questions which leads to a move into social talk initiated by the patient:

Extract 2: PA. A1

1	Nurse:	is there any ↑family history of heart problems?
2	Patient:	err just ma dad there (.) just bit of angina
3	Nurse:	°right°
4	(1.0)	
5	Patient:	at ninety it's not bad ↑eh
6	Nurse:	I know it's (.) how is (.) did they have to ↑admit him for his
7		fall?=
8	Patient:	=aye well (.) we thought he was all (1.0) the way he'd fell
9		ehm (0.6)
10		he'd got himself into a lot of pain in hisself so (.) but he's
11		↓fine so=
12	Nurse:	=oh that's good
13	Patient:	but you can't remove the pain so (.) that's what Judy ma wife
14		said eh (.) she said it's really bad at that (.) especially at that
15		↑age
16	Nurse:	yeah
17	Patient:	but ↑aye he's fine he should be oot today
18	Nurse:	°good°
19	Patient:	hopefully
20	Nurse:	°good°
21	Patient:	ma mum's eighty (.) and she's (cannae) (0.4) she cannae err
22		(0.2) help 'im anymore yer know [what I mean
23	Nurse:	mhmm [mm
24	Patient:	she's got her ain problems but (0.3) so
25	(0.8)	
26	Nurse:	[does he live near ↑yer
27	Patient:	[( ) oh tee ↑aye (0.2) aye
28	Nurse:	nearish
29	Patient:	aye Banham near Livingstone[4] ( ) but (1.0) Hhhh
30	(2.0)	

[4] All place names have been changed.

31 Nurse: what about strokes is there any family history of ↓strokes

At line 5, the patient offers an evaluation of his father's health ('(at ninety) it's not bad eh', l.5) which simultaneously provides a format which does not interfere with his readiness for surgery (angina at ninety is not exceptional or likely to constitute an inherited condition) whilst also issuing a potential social/off task topic proffer. After two restarts (perhaps in response to her uncertainty about the function of this turn) the nurse takes up and develops this topic, using her prior knowledge of the patient's father. She also offers affiliative agreement (line 16) to what might be seen as the emergence of troubles telling on line 14: 'she said it's really bad …especially at that age', and offers repeated positive assessments in response to the more optimistic framing of the patient's father's situation (lines 12, 18 and 20). At lines 21 and 24, the patient makes further attempts to develop the topic in stepwise style, by discussing his mother, but this is not pursued by the nurse (who at this point offers only minimal neutral response tokens (line 23)), rather she returns to the initial topic (the patient's father), asking whether he lives near the patient, and then returns to the on-task sequence with a disjunctive topic switch (Jefferson 1984a) on line 31.

This extract, where, significantly, social talk is initiated by the patient, is the first that perhaps begins to problematise the distinction between on and off task. The social talk that the patient initiates about his father could be seen as a form of health-related 'troubles telling' which is initially oriented to with troubles-relevant responses by the nurse, and demonstrates the interrelated nature of medical problems and people's social lives.

However the patient's attempts to develop troubles talk about his mother are not supported by the nurse, suggesting that 'troubles resistance' may be a feature of troubles talk when it emerges in institutional sequences. Across our data, we observed that troubles-telling initiated by the patient and emerging in social or small-talk sequences was frequently diverted or curtailed by the nurse (Maynard 2003: 105), and that forms of 'troubles resistance' were unusually displayed by the troubles *recipient* (rather than teller)[5]. Furthermore, the nurse's orientation to 'positive' news (her repeated assessments of 'good') and her lack of engagement with the 'bad' news (that his mother is struggling) might also be seen as a bid for a 'good news exit' (Maynard 2006) and thus means of closing the sequence. We will see further evidence of this kind of 'optimistic' exiting from troubles-relevant talk in later sequences.

Another example of the ambiguous relationship between social and troubles talk can be seen in the next extract.

Extract 3 PA. A4

1 Nurse: and (.) obviously no strokes or mini strokes for yourself?=
2 Patient: =↑↑ooh (.) I tell a lie my sister (.) my ↑sister who's
3 ↑younger than me has had (.) two strokes in the last ye:ar
4 Nurse: ri:ght
5 Patient: just thought I'd mention that (0.8) she's had two strokes
6 she's two years younger than me she's forty eight (.) she's-
7 she's had two

[5] see also Mandelbaum (1991) for a similar observation in relation to complaints.

8	Nurse:	[what a shame
9	Patient:	[strokes yep (.) she's now having (.) what they think are
10		associated ↑seizu:res=
11	Nurse:	=ri:ght (0.2) [what a ↑shame (.) yeah
12	Patient:	[so (0.2) that is a shame they've taken- revoked
13		her driving licence and everythin' (0.2) so (.) but they've given
14		her a bus pass so (.)£what that'll mean£ hhhhh
15	Nurse:	heh heh heh heh
16	Nurse:	£ehm£ (.) circulation no problems with your arteries or

The patient has previously been asked about whether there is any family history of heart trouble. Here the patient's introduction of her sister's history of strokes is initially relevant to the institutional task of medical information gathering, even if it disturbs the expectable interactional order of routine history taking[6]. However the elaboration of this information, the inclusion of the sister's relatively young age and description of the lifestyle consequences of these strokes suggest that the patient may be moving into off-task or social talk. This analysis is supported by the nurse's non-medical, affiliative and troubles-oriented responses on lines 8 and 11: 'what a shame', which is aligned to this shift in footing.

However we could also interpret the patient's discussion of her sister as the introduction of a topic that she believes *may* be relevant to the question. In routine information gathering about a patient's health status, patients are sometimes uncertain about how much information to disclose and what is relevant to the encounter, a phenomenon observed by Heritage: 'physicians and patients both cooperate and struggle with one another over "what matters" in a given medical context' (Heritage 2010: 46). Interestingly, at an earlier point in the extract we can see the patient also negotiating the tricky issue of deciding 'what matters' in her own account. On line 5 she says 'just thought I'd mention' which orients to the possibility that her contribution may be surplus to the information required by the institutional agenda.

From line 11, the patient enters into a description of the lifestyle consequences of these strokes thus developing the 'troubles telling' sequence. This is not taken up again by the nurse and possibly in response to this, the patient moves towards a closing of this sequence with the introduction of humour and laughter (in relation to her sister being issued with a bus pass). This move towards closure is also oriented to by the nurse whose own laughter prefaces the initiation of a new questioning sequence. Jefferson notes that laughter often occurs after the production of trouble-telling (Jefferson 1984b: 346) and is sometimes associated with troubles-resistance or exiting from troubles talk. However we might deem that this turn to humour is also a means of moving out of a potentially *irrelevant* sequence – both nurse and patient agreeing that the topic is something social and amusing and thus collaborating to close it down without threat to face.

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[6] Boyd and Heritage have noted that 'routine history questions are designed to favour… "no problem" responses' (2006: 162). Such questions embody particular 'best case' preferences (what Boyd and Heritage term 'optimization') via e.g. negative polarity 'I presume you haven't', 'no asthma, no breathing difficulties?'.

An interpretation of sequences 2 and 3 then is that patients are initiating 'troubles relevant' talk that moves beyond the strict agenda of the medical history taking and implicitly reveals a concern about their or their family's health. Sometimes this troubles-relevant talk is a function of a patient's uncertainty about what is relevant to tell in reponse to history taking questions, and the nurse must orient to a lack of relevance by negotiating a closing of this sequence in order to return to the business at hand. However, troubles-telling poses difficulties for both teller and recipient in terms of moving from the troubles-telling phase to other topics: 'a central feature of troubles-talk was the constant tension between attending to the trouble and attending to business as usual' (Jefferson 1988: 419). In an institutional sequence where there is a time-restricted medical agenda to pursue, these difficulties are arguably even more acute, particularly for the troubles recipient, for whom a transition away from troubles talk and back to on-task talk may be contrary to a patient-centred ethics. We see an extended example of this difficulty in the next section, where health-related troubles talk emerges in a social sequence[7],

The emergence of troubles telling in social/small talk sequences

In the following long extract (analysed in two chunks), we see a particularly clear example of troubles talk emerging in a social/small talk sequence during a non-verbal procedure where, unlike the history taking sequence, troubles-incipient talk is unlikely to be a response to a task-oriented question. The nurse is about to conduct a 12-lead ECG (heart tracing). During this sequence, six electrodes are attached to the chest and four elsewhere. The patient is lying on the bed with chest naked.

The patient has been describing a fertility procedure undertaken by his wife which led to her successful pregnancy, which then leads to a discussion of his (now adult) son and some of his health problems. Throughout this sequence the nurse negotiates a delicate line between foreclosing personal disclosure without completely disattending the topic. Her responses are strongly affiliative and positive in response to 'good news', but more discouraging in relation to 'bad news', an asymmetrical order remarked on by Maynard: 'good news is celebrated and not diminished; while bad news and the accompanying feelings are cushioned and countered' (2003: 184)

Extract 4: PA. A1

1	Patient:	..within weeks she was ↑pregnant=
2	Nurse:	=↑↑oh that was ↑↑good
3	Patient:	she never kept very good (in some ways) bad (.) we
4		nearly lost him three times
5	(1.0)	
6	Patient:	err (.) that wuz (.) he's got that d- developmental dyspraxia
7	Nurse:	((attaching 'stickies' for the ECG)) ri:ght
8	(0.3)	
9	Patient:	that was just that was I always (.) think that's a job you're
10		in you're- always looking at people (0.4) and erm (0.4) always

[7] Hudak and Maynard also identify in their doctor-patient data this kind of 'activity contamination' (Jefferson and Lee (1981)) whereby small talk develops into a complaint involving the participant as a patient.

11		saying oh there's something not right (oh it's just)
12	Nurse:	what age is he?
13	Patient:	he's now twenty three
14	Nurse:	((leaning over patient to attach leads)) right
15	Patient:	and last night when we were leavin (.) err (.) he wuz (0.8)
16		that wuz half eleven we left (.) no (it'd be) eleven and err
17		(1.8) he wuz clearing out his ↑cupboards (0.4) [tearing up]
18		°and I mean° (we're) talking everything out his cupboards in
19		his room (0.8)( )the chaos (the) er the (um) oo cee dee
20	Nurse:	right (0.5) and is he ↑workin? (.) or
21	Patient:	no he's ( ) he went to university eh and did (0.4) (he)
22		(1.8) hurhhh I don't ken how much yer know about it don't want
23		to bore you (that) if there's something wrong with it but (1.0) we
24		discovered that (0.4) he was struggling he had meltdown at
25		university (he got into) university (.) err doing computing science
26	Nurse:	↑↑good
27	Patient:	and he had err he had a meltdown (.) an one night he was
28		sittin (.) he wuz sittin (0.4) he sez ahh hh he sez (on the edge)
29		sittin on the edge of a h- a a precipice looking down at a black
30		hole and I was like (well) sit doon (0.4) talk tae us
31	Nurse:	right
32	Patient:	yer don't have ta stay at university (0.2) it's too much
33	Nurse:	((inputting information into ECG machine)) yehh
34	Patient:	at that time we didn't know it was dyspraxia but (.) ah
35		dinnae (.) thought was something wrong ( ) and err (1.2) so ah
36		encouraged him to go to the learning support (0.8) and err (1.2)
37		they really weren't dead keen because what d'ya want us to do at
38		this late stage (.) but what happened was (0.2) err ah encouraged
39		him to go back and insist that he got ↑looked at)
40	Nurse:	↑aye
41	Patient:	( ) so he got an educational psychologist report and and in
42		that report (.) they considered it a remarkable achievement that he
43		got- that he's achieved ta date what he ↑did
44	Nurse:	aha
45	Patient:	and err
46	(1.8)	((nurse is leaning over patient to check leads))
47	Patient:	((inaudible – microphone distortion))
48	Nurse:	ri:ght
49	Patient:	(cos)
50	(1.8)	
51	Patient:	five percent of the population's got that (.) y'know=
52	Nurse:	=right
53	Patient:	that high
54	(1.0)	((microphone crackling))
55	Patient:	n his reasoning was (.) all shot ta pieces his short term
56		me:mory and stuff
57	Nurse:	right
58	(0.8)	
59	Patient:	[( )shave ma chest if it's

The sequence begins with the disclosure of his wife's successful pregnancy in the past. The nurse's response to this unequivocally good news is strongly affiliative and positive, evidenced also in the high pitch intonation '=↑↑oh that was ↑↑good'. On line

6, the patient discloses that his son has developmental dyspraxia (a neurological disorder which affects physical coordination and may also include memory loss) and also reveals other mental health issues such as 'OCD' (obsessive compulsive disorder) that are prompting alarming behaviour. At this point we start to see evidence that this kind of 'troubles talk' prompts less obviously affiliative responses from the nurse. On line 7, she offers a neutral acknowledgement or continuer ('right') in response to the information about the patient's son's dyspraxia, though she is notably attaching sticky pads to the patient's chest at this stage, so may be slightly distracted. In response to his turn about how he came to suspect all was not well with his son (9-11) she orients to a more neutral aspect of the story through the use of a factual question ('what age is he?' (l. 12). Similarly following a narrative sequence in which the patient describes how his son was obsessively cleaning out cupboards the night before, she asks a further factually-oriented question: 'and is he working?' (l.20). The status of these factually-oriented questions is ambiguous. Firstly, these questions may have a 'health' inflection. From the perspective of a nurse, an understanding of the son's condition is afforded by details of age and capacity (i.e. does his condition enable him to work?). Secondly, by not providing sympathetic assessment or affiliation in response to the patient's story, the nurse appears not to be orienting to the talk as 'troubles-telling'. This may be a function of the nurse's desire to maintain a professional distance, to respect the privacy of the patient by not probing or encouraging the emotional elements of his disclosure, but could be deemed a subtle form of 'troubles resistance'. There is evidence in the patient's talk of an awareness of the accountable nature of 'troubles talk'[8], when he inserts 'don't want to bore you' (l. 22-23) in his narrative, though in other respects his turns do not reflect a sensitivity to the arguably disattending nature of the nurse's turns.

However, we see a different kind of nurse response in receipt of 'good news'. On line 26, the nurse responds enthusiastically to the information that the patient's son had got into university to study computing science ('↑↑good'). This selection of one (positive) element of the patient's troubles talk to which to respond might be thought to be a form of 'subtle disattending' (Mandelbaum 1991: 97-98) which fails to orient to the 'complaint frame' (Mandelbaum 1991: 97), and as an arguably premature assessment may discourage news elaboration (Sacks 1992: 573). The patient does in fact continue to orient to a complaint frame, despite the nurse's absence of troubles recipiency. Between lines 27 and 30 he continues to disclose personal information about his son's possible breakdown and suicidal thoughts. Again, the nurse's response is a minimal 'right'. Between lines 32 and 43, the patient continues his narrative about his son's experiences at university and the eventual diagnosis of dyspraxia. During this telling, the nurse is having some problems with one of the leads and her attention is distracted, meaning there is probably minimal eye contact, and her neutral, non-troubles-oriented responses are likely a function of this.

On lines 42-43 the patient offers a summarising assessment of his son's progress in positive terms: 'they considered it a remarkable achievement that he got- that he's achieved ta date what he ↑did'. The patient's treatment of the nurse's response as inadequately affiliative due to her distraction with the leads is possibly revealed by

[8] Moral and accounting work also frequently accompanies the related activity of complaining (e.g. Drew and Holt 1988; Edwards 2005; Stokoe 2009, Benwell and McCreaddie 2016).

his hesitation on lines 45 and 46. After the patient describes the common occurrence of dyspraxia: 'five percent of the population's got that (.) y'know=', the nurse provides a further minimal token 'right', which demonstrates an orientation to the on-going nature of the telling and its epistemic progression (Gardner 2007), but does not encourage expansion. As the patient's contribution is a kind of aside to his main narrative, the production of an epistemic progression token at this point, rather than a news receipt token or assessment, may suggest that the nurse's attention is slightly distracted. This is followed by a turn extension or 'increment' by the patient (Schegloff 1996) 'that high' (l.53), which Schegloff notes can be seen to address an absence of response. Although the patient's stance in line 51 is implicit, the increment makes the stance explicit in the form of an assessment and lends support to the idea that he is displaying an orientation to the inadequacy of the nurse's response in l.52.

On line 59, the troubles telling sequence is temporarily suspended by the medical context which diverts the patient's attention to the non-verbal task. The nurse has been struggling to attach the leads to the patient's chest and the patient offers to have his chest shaved in order to facilitate this. This is an unusual example of a move into on-task talk being occasioned by the patient, and demonstrates his awareness of the needs of the non-verbal process, and possibly by extension, his awareness of how these needs have occasioned a distraction from his narrative. This is a clear example of how boundaries between social and on-task talk are provided by the sequential relevance of a return to medical talk. However, the patient resumes his 'social' talk in the next sequence (a series of lines (60-71) relating to the attaching of the lead have been omitted).

73	Patient:	so that was ↑it
74	(1.8)	
75	Nurse:	£have you got ↑↑cream on£
76	(0.2)	
77	Patient:	no
78	Nurse:	no:
79	(7.0) ((inaudible talk of both parties))	
80	Patient:	so he graduated but no- (.) never got an honours
81	(0.8)	
82	Nurse:	but he got his ↑↑degree?
83	Patient:	aye
84	Nurse:	that's ↑↑brilliant
85	Patient:	£it is aye£
86	Nurse:	absolutely ↑bri:lliant
87	Patient:	he's murder to live with but
88	(0.8)	
89	Patient:	he's dying ta move on but ( ) the things he does is
90		like (0.4) he leaves the light on and the back door o:pen (.) ah
91		mean unlocked and ↑open (0.2) err goes to his bed (.) and some
92		nights he's done it (.) he's locked it an
93	Nurse:	ri:ght
94	(1.0)	
95	Patient:	leaves the oven on and things like that (.)°you need to keep
96		an eye on him° (0.9) seems ta be getting £worse£ than (.) better
97	Nurse:	mhmm
98	(1.4)	
99	Patient:	°if that makes° ↑sense

100 (1.4)
101 Nurse: we'll get you to lie nice and still [just a wee minute

The patient provides a series of summative assessments of the previous narrative 'so that was ↑it' (l.73) and 'so he graduated but no- (.) never got an honours' (l.80) which reveal a sensitivity to the bounded nature of the social talk and its legitimate interruption by on-task activity. However, these assessments arguably also operate as bids to reinitiate the discussion and suggest that for the patient, the troubles telling is on-going.

On line 82, the nurse again selects a positive element of the narrative 'but he got his ↑↑degree?' and uses this as a way of recasting a troubles telling or negative news as something positive. This is supported by a series of highly positive affiliative assessments 'that's ↑↑brilliant' (l. 84) and 'absolutely ↑bri:lliant' (l. 86). This tendency for positive sequences/assessments to entail from negative sequences/complaints has been commented upon by a number of studies (e.g. Beach 2003 on 'managing optimism'; Holt 1993 on 'bright side sequences'; Maynard 2003 on 'good news exits') and all commentators note the relationship between this positive recasting and a movement towards topic closure, which suggests there is a strong relationship between troubles resistance and optimistic projection. In our sequence, the patient's resistance to this optimistic trajectory (he returns with a further negative assessment of his son's situation 'he's murder to live with' (l.87) is perhaps also an act of resistance to the closure-relevant character of the nurse's assessments. It is significant that he goes on to elaborate on the nature of his problems at this point (ll. 89-96)).

On line 96, however, the patient seems to move towards closure of this troubles telling sequence. He deploys a 'smiley voice' to deliver an aphoristic statement about his son: 'seems ta be getting £worse£ than (.) better'. The use of wry humour here, downplaying his troubles, is arguably a form of troubles resistance on the part of the patient and may index an attempt to close down this troubles telling sequence and relieve the nurse of her role as troubles recipient (Jefferson 1984b). At this point the nurse's response is minimal and notably neutral 'mhmm' which perhaps responds to the close-implicative turn of the patient, making 'light' of his troubles, though it may also prompt a turn increment '°if that makes° ↑sense' on line 99. The nurse does not respond to this (note pause on line 100) and then makes a disjunctive shift to the on-task activity.

In this sequence, the patient's introduction of emotional, self-disclosing and personal material into a social sequence transforms the 'small talk' into something more akin to 'troubles telling'. The subtle resistance to this trajectory by the nurse, partly due to her involvement in on-task medical activities, and indexed by minimal responses that acknowledge an on-going narrative but which do not encourage its expansion, is suggestive that troubles telling is not a genre of talk that can be easily accommmodated by routine medical encounters.

Conclusion

In the preceding discussion, we explored a number of issues relating to the distinct phases of talk in medical interactions between healthcare professionals and patients which might be broadly termed 'on-task' and 'off-task'. We observed an implicit interactional order which suggests that in institutional settings, small talk does not normatively become too 'involved' or develop into troubles telling, and remains 'small', largely because otherwise it is likely to interfere with the institutional task being undertaken. When social talk that is initiated by patients within the on-task sequence is curtailed, there appear to be few social consequences. Topic proffers by patients in these circumstances are 'interactionally risky' (Hudak and Maynard 2011: 648), and patients seem to implicitly understand the possibility that the nurse's attention will be diverted by the on-task activities. However, the interactional order becomes more problematic when patients introduce elements of 'troubles telling' into the social phases of interaction, particularly where these troubles have a distinctive 'health' character. In the cases where health-related troubles talk arguably emerged in healthcare interactions (both in response to history-taking sequences and within social talk), the nurse tended not to orient explicitly to the talk *as* troubles talk. This took the form of selective orientations to 'good news' within the sequence, neutral continuers which did not encourage the 'heightened' emotional or affiliative response that might be expected from a troubles recipient (Jefferson 1988), and close-implicative moves such as the collaborative construction of humour or aphoristic statements, both of which might be thought to have 'troubles-resistant' effects.

The motivations for some of the patterns we find in the data can only be speculatively addressed[9], e.g. that the nurse doesn't want to get drawn into emotional disclosure because of the associated labour of emotion and time that would be implicated. 'Small' and 'social' talk have a ratified and valued role within routine healthcare encounters and are often initiated by and faciliated by nursing staff. However, when 'small' talk becomes too 'big' (either too lengthy or too consequential in medical or emotional terms), it is subtly disattended, and the task (whether history taking or non-verbal procedure) not only curtails the troubles talk, it may even be used strategically to 'move things on'.

The evidence of some of these sequences arguably presents a series of issues which might be helpful to acknowledge in the context of healthcare communication training, e.g. the implicit assumption that emotional and personal disclosure is an activity not normatively associated with certain kinds of institutional encounter and that troubles talk emerging in small talk sequence may be a bid for more medically-oriented responses. One reason why providers may, as a matter of course, resist the status of a troubles recipient is because any patient-initiated small talk may be liable to be heard as troubles talk incipient, which takes both social, temporal and cognitive resources away from medically-focused activities. In the long extract (4) analysed above, however, the cumulative seriousness of the trouble related by the patient, his perserverance with a 'troubles telling' despite the nurse's absence of troubles-orientated responses, might be thought to merit a more focused intervention by the nurse.

[9] In the introduction to Antaki's 2011 collection on Applied Conversation Analysis, he makes the point that CA 'interventions' into professional communication may need to substantiate their observations with appeals to ethnographic approaches (Antaki 2011: 12-13).

Such observations have important training implications for providers, for example to raise awareness of how to distinguish social talk from troubles talk, and may also provide some opportunity for future research on affiliative responses. Nurses have been identified in the research literature as occupying a specific kind of medical role which is better positioned to be able to articulate the relationship between health and social life more generally as well as being more attentive to how patients may intimate or allude to concerns, fears and troubles with their health providers. The kinds of data analysed above provide evidence for healthcare providers to better contextualise specific health concerns within patients' broader lifeworlds and to respond to the profession's concerns to promote patient-centred healthcare. It is possible that the clear blue water that healthcare professionals generally preserve between on- and off-task talk might be usefully muddied a little in a context of patient-centred care and in the interests of the humanization of the medical agenda.

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