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Commentary

Fast healthcare: Brief communication, traps and opportunities

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ABSTRACT

Resource considerations have meant that brevity in health care interventions is a high priority, and have led to a constant striving after ever more impressive time efficiency. The UK's National Health Service may be described as a kind of 'fast healthcare', where everyone is task busy, time is money, bed spaces are frenetically shuffled so as to accommodate the most needy and there appears to be 'no time to talk'. Indeed, a great many health care encounters are taking place in short 'blips' often of 5 min or less across a range of sites and involving a vast number of practitioners. In this paper we explore how brief communication can both alienate and be therapeutic for patients. We theorise brief interactions by considering a number of traditions of work in anthropology, linguistics and sociology and conclude that health care providers need to invest much more in the skills and strategies for how best to communicate briefly if it to retain its core tradition of caring for others.

1. Introduction

In this paper we will offer a theoretical and practical perspective on the issue of brief communication in health care. Many difficulties within health care settings and grievances from patients can be attributed to problems in communication. Shortage of time is often cited as a reason why practice cannot achieve the levels of mutuality and emotional warmth which are desirable. In response to this dilemma, we offer here a means of thinking about, and enhancing the communicative value and emotional tone of relatively fleeting opportunities for communication in busy healthcare environments. This can improve the experience for patients and add value to the working life experience of practitioners.

1.1. Fast healthcare: process focused and ends driven

Brevity in health care interventions remains a high priority, not least because of economic imperatives and the constant striving after ever more impressive efficiency. We might characterise the UK's modern National Health Service (NHS) as 'fast healthcare', where everyone is task busy, time is money, staff partake in 'musical beds' and there appears to be 'no time to talk'. In fact, the health service in the UK appears to be part of a society which over a quarter of a century ago Toffler [1] envisioned as 'blip culture'. In this, 'instead of receiving long, related 'strings' of ideas, organized or synthesized for us, we are increasingly exposed to short, modular blips of information - adverts, commands, theories, shreds of news...' [1, p. 182]. In the same way, a great many health care encounters are taking place in short 'blips' often of 5 min or less across a range of sites and involving a vast number of practitioners. From acute admissions wards to nursing homes, from scanner suites to complementary practitioners, NHS walk in centres to plastic surgeons, the public encounter a variety of fragments of health care communication, and may readily gain the impression that treatment interventions are similarly disconnected.

In this fast healthcare culture, it is often felt that interpersonal communication is far from ideal. So called 'poor communication' in clinical settings is the largest source of patient dissatisfaction [2–4]. Inadequate professional communication has been consistently cited as a cause for concern by Ombudsman Reports on the NHS in the UK (www.ombudsman.co.uk), various commentators, such as Petit-Zeman [5], have attempted to provide wake up calls and a number of government initiatives and policies demand improvements, not least Essence of Care [6], Tomorrow's Doctors [7], and Good Medical Practice [8].

In this paper, we argue that a key concern should be that of countering the increasingly process focused and 'ends driven' nature of the UK's NHS, which is caught up in the drive to shorten waiting lists and reduce costs. This may result in a reduction of the length of time allocated to each patient. This process-orientation to health care delivery can result in a negative, 'glancing' and denaturalised form of communication that may alienate the

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patient or service user. He or she may register little human engagement and warmth in such speedy transactions, simply being a time obstacle, something to get through or get rid of. Commenting on prescriptions as a kind of closure device in 'communicating' with patients, an NHS doctor betrays this ethos: 'It's a nice way of getting rid of the patient; you scribble something out and rip the thing off the pad. The ripping off is really the "Fuck off"' [9, p. 732].

1.2. Lack of time in practice environment

Indeed, organisational constraints in the modern NHS tend to press staff ever more firmly towards brevity, yet most interpersonal models of care foregrounded in the literature tend to emphasise aspects of the process which require time for interaction and mutual storytelling. In practical contexts communication is often targeted rather than utilising discursive approaches. To date, interpersonal philosophies and frameworks of care found in the educational literature have tended to avoid time-consciousness as a key issue [10], and instead promote more extended forms of communication based around notions of therapeutic relationships, deepening empathy, mutual understanding and regard for clients. Yet time shortage affects the level of care which is achievable. In a 1999 study of eight UK NHS general practices, the most commonly mentioned concern relating to the practice environment was lack of time, and the study noted that the strength of feeling about this was considerable as it was seen as hindering effectiveness in many aspects of medical practice [11].

As Christakis and Feudtner [12, p. 742] put it:

> Although most patients may perceive a 2-minute encounter with a physician seated at the bedside as more reassuring then a 2-minute chat with him standing at the doorjamb, 2 minutes is still only 2 minutes; patients placated enough to comply (or not complain), still may not feel connected to their physicians in any meaningful sense... The healing touch in major medical centers rarely lingers.

In this context, as some authors have suggested, the role of communication may even be to revise patients' expectations downwards, so that grievances over the lack of time, treatment and other resources are managed by the health care personnel [13]. Indeed, in a time of neoliberal retrenchment and retraction in public services, and health care in particular [14], communication may obfuscate rather than enlighten. The destabilisation of health care organisations and arrangements by policymakers itself presents particular difficulties for those seeking to provide adequate services and improve patient experiences [15].

1.3. The need to invest in skills and strategies for brief communication

In this paper however we will not attempt a critical analysis of the healthcare policies which have led to the flaws identified, but rather we will focus on the more beneficent consequences that a mastery of brief communication in health care could bring and how this may address some of the frequently identified shortcomings. Whilst policy objectives and their unintended consequences provide the context for many of the difficulties, our concern here is with the interpersonal and psychosocial aspects of the communicative environment.

There is a great deal of literature which emphasises the importance and value of good interpersonal relations between patients and professionals in health care, yet a major issue facing health care professionals is that of finding time for communication with them. At a point in history when many practice areas, clinics and teams are increasingly task driven and concerned to boost their productivity, communication can slow down the 'people processing'. There is a sense then that communication can 'get in the way' of health care encounters. There are a great many situations where punctuality is at a premium and time is of the essence. Getting nursing home residents ready for bed, administering injections or weighing infants can all be performed more speedily if communication is kept to a minimum. From the clients' point of view this is often most unsatisfactory and can lead to a sense of alienation and complaints that care is perfunctory or inhumane. Indeed, where clients are confused or require reassurance it might even lead to violence [16]. This kind of taciturn brevity is disappointing, and suggests that the NHS needs to invest much more in the skills and strategies for how best to communicate briefly if it is to retain its core tradition of caring for others.

1.4. Brief communication, the way forward

In this paper we aim to distil from existing literature and our own research a means of making sense of how health care encounters can be warm, congruent and effective even when they last less than 5 min or less. As we shall see, even momentary communications can convey support, warmth and a sense of inclusion. In other words, alongside the traps in communicating briefly that lead to an impression of being dismissive or cold, there are also opportunities for optimising brief, affirming interactions and skilled, person-focused 'ordinariness'.

This leads to an interest in the pragmatics of communication, and there are implications for teaching skills to future healthcare professionals, to facilitate skills in delivering a subjective sense of 'high quality' engagement in the briefest time. This is valuable in consultations, carrying out tasks or interventions or when meeting patients in unstructured ways, for example, along corridors. The skill element in communication might be more to do with strategies for identifying and responding to opportunities for interaction—so successful health care communicators may be those who adapt to task-dominated environments and utilise even momentary time slots to good effect. This backcloth of successive momentary engagement and warmth could create a positive realm for recovery.

1.5. Personal and professional styles of communication

The impetus for considering brief communication in health care comes from several sources. Our observations have suggested a curious contradiction. The brief kinds of jolly, supportive, or encouraging communication used in everyday life with friends and family often disappear in clinical sites. In other words professionals seem to adopt formal, neutralised expressions in preference to ordinary and emotionally generous remarks or gestures. Sometimes, whereas the briefest of conversations with a friend can leave one with a good and lasting feeling of self-worth, the kinds of neglectful, perfunctory or unemotional exchanges that clients complain about in clinical sites can leave them feeling profoundly isolated and ignored. The transformational strengths of brief, kind, ordinary and friendly exchanges appear overlooked in health care.

Traditionally, health communication curricula have focused on teaching counselling and processing skills—the former welded to professionalism and expertise; the latter to business and economic efficiency. But the simpler, briefer interactions, for example an authentic smile, are demoted as taken for granted. In this paper we are intending to explore some of what is missing from many clinical encounters, and explore some means of thinking about or theorising this element, by considering traditions of work in anthropology, linguistics and sociology which have tried to grasp how this immediate sense of warmth is generated. This will equip

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us to explore in finer detail how this inconsistency comes about between personal and professional styles of communication, and suggest how health professionals can be enabled to make the best use of the few moments of consultation time they may have. Health professionals are increasingly called upon to demonstrate the effectiveness not only of specific interventions but of their role as a whole. The practitioners are often perfectly capable of making friends and family members feel good from a very brief interaction. Yet in Kasper's [17, p. 2] words, they 'don't always use what they know' in professional contexts.

In essence, a focus on brief communication may break the logjam of traditional counselling approaches in health curricula that skew towards mental health contexts. It would promote quick, generic and pragmatic communication along an axis of skilled ordinariness. As Burnard [18, p. 682] puts it, when talking about mental health nurses:

> [they] may be remembered as much for their friendliness and ordinariness as for their counseling skills. Ordinary chat might be as important as therapeutic conversation.

This opens up a number of possibilities. For example, some styles of communication are a kind of time management. Closing a consultation may be expedited by gestures like closing the file, or as we saw above, writing a prescription and tearing it from the pad. In order to expedite rapid, effective and emotionally supportive communications, practitioners need a conception of communication adapted to the practical constraints of healthcare environments. At present a good deal of training is driven by an implicit model that sees counselling as the ideal to which practitioners should aspire [10]. However, often in practice settings task-focussed communication that conveys meanings in a minimal or economic way is often the target. This invites the question of whether it is possible to extract the best elements from 'time generous' philosophies of communication and apply them to 'time sensitive' settings of the kind in which health care is often practised or whether we need wholly new ways of thinking about 'blip culture' health care.

Making sense of how a whole lexicon of feelings and ideas might be communicated in relatively short health care encounters involves us in re-theorising communication in health care in a way that does not demonise professionals or see lack of communication as a 'deficiency' in 'skills'. Instead we want to develop a new conception of brief health care communication along the lines of what can realistically be achieved in demanding situations.

1.6. Facilitating positive experiences and desirable outcomes

In what follows we will draw on four key ideas which we have found useful in emphasising the role of brief communication in facilitating positive experiences and desirable outcomes, as well as countering the difficulties in communication which are sometimes fostered by task busy environments. We have divided these up into issues concerned with emotional tone; the elicitation of a sense of trust and respect across cultural and socioeconomic boundaries; the creation of a 'time tardis' effect; and the role of phatic communication.

2. Emotional tone and display

In brief encounters in health care settings, whilst there may be limited opportunities for extensive information exchange, the relatively fleeting interactions may contain ample opportunities for emotional tone to be conveyed. For example, tired, dour expressions and lacklustre demeanour, combined with monosyllabic, grumpily delivered speech communicate a message of misery in a matter of seconds. The effects of emotions and moods in health care settings can be complex and varied, in line with participants' socio-cognitive constructions of their emotional situations.

When the interactional encounters in a workplace setting have to involve a particular kind of emotional tone, the term 'emotional labour' is sometimes used, a concept promoted by Hochschild [19] in a study of aircraft cabin crew, who had to maintain polite and pleasant demeanour even on long and arduous flights. She noted that emotions were displayed according to a 'set of shared, albeit often latent, rules' [19, p. 268] which governed the kinds of emotions which were specific to each situation. The parallels with the work situation of health care practitioners are notable [20,21]. Emotional labour, across a whole range of service industries, has been described as the effort involved when employees 'regulate their emotional display in an attempt to meet organizationally based expectations specific to their roles' [22, p. 365]. It is also closely related to Strauss et al.'s [23, p. 254] 'sentimental work', a concept introduced to help explore the possibility that 'there was more to medical work than its physiological core'. While Strauss et al. [23] compare 'sentimental work' to tender loving care, they also point out that it is performed as a means of getting the 'work done effectively' rather than exclusively out of humane concerns.

Emotion work is closely allied to the idea that there are 'display rules' or 'expectations' formally or informally governing the kinds of emotions that can be expressed and how they may be exhibited. Practitioners may want to portray emotions in accordance with display rules because they care about their clients or keeping their jobs, and there are occasions when genuinely felt emotions do not concur with those it is judged appropriate to display. Feeling one emotion and displaying another is at the very heart of emotional labour.

As well as displaying certain emotions, emotional labour involves controlling others. Emotional labour strategically allows practitioners to present an impersonal approach to colleagues, clients and society as a whole, especially when dealing with difficult moments such as death and dying [24], mistakes [25], and with the uncertainties inevitably involved in trying to apply medical knowledge [26].

> Often, there is a sense of trying to fit one's emotions to those of the client one is dealing with at the time. A nurse in Staden's [27, pp. 152–153] study said that when working with a depressed or distressed patient, 'even if you may be feeling quite buoyant yourself, you will dampen down. . .the image you portray on your face. . .so that it matches. . .the mood'.

Emotion work could be deployed strategically to achieve therapeutic ends. A nurse's caring skills are in a sense a political instrument as they may be used as a resource to manipulate the image of health care in order to achieve financial [28], or 'socio-cultural and wider political ends' [29, p. 393]. Yet emotion work in health care settings is not exclusively about an economically motivated process of exchange. As Bolton [20] argues, as social beings, emotion management by health care practitioners is a way of 'paying respect with feeling'; it is a personal gift given freely, sometimes unconsciously, and sometimes without the counting of costs. As Mann and Cowburn [21] add, many practitioners felt that their emotional labour performance helped the clients cope, and Bolton [20, p. 86] described nurses as 'accomplished social actors and multiskilled emotion managers'.

3. Creating a sense of trust and respect in brief health encounters

The fleeting and transient encounters between strangers that are characteristic of heath care in the UK seem set to become even more widespread. Rather than the mutual understanding achiev-

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able in a longstanding relationship with a GP, ever larger numbers of patients will be seen by a variety of professionals employed by group practices and primary care trusts. In the UK also there are telephone helplines, walk-in centres and a variety of outreach services for sex workers, rough sleepers and other marginalised groups, all of which are supplementing traditional primary care arrangements and which provide fresh challenges for any attempt to generate a sense of mutual respect. The NHS itself claims that five million patients have used its walk-in centres and more are opening, especially at railway stations [30].

The brevity of encounters between practitioners and clients who have had little or no prior relationship are perhaps also given context by the growing rate of migration between nations. This further reduces the opportunities for longer term supportive relationships to develop between health care providers and clients and highlights the necessity for effective brief communication that can elicit trust and convey respect across language or cultural divisions. It is estimated that 8% of the European population and 11.5% of the US population could be classified as migrants [31].

This may yield particularly acute difficulties where migrant status is compounded by the presence of health problems about which there may be some embarrassment or stigma. In terms of migrant sexual health, Serrant-Green [32] notes that research into problems identified by minority ethnic participants accessing sexual health services suggests the desirability of a greater focus on issues relating to the lifestyles of ethnic minorities, which would enable practitioners more readily to convey an atmosphere of trust and respect.

A further example of the intersection of social marginality with a stigmatized health condition is provided by the case of HIV infection. There are a number of aspects of communication between practitioners and transient or socially marginal clients that clients feel are important yet do not necessarily take long to establish. Here are some participants in a study by McCoy [33] of the experience of being both socially marginal and HIV positive discussing what they find desirable in their relationship with their doctors.

> *Participant 1*: It is a trust thing. I do not mean I want to get personal with them, I just want to feel that they are not aloof, they are not above me, they are not better than I am.

> *Participant 2*: For me it is comfort level. That is, you know, to have a relationship with the doctor is that I have the comfort level that I feel that I can ask or scream in his or her face if I feel I need to and that is going to be accepted as OK—not that I do. That if I really feel strongly about something that I can say it. A respect. (FG 11) [33, p. 798]

These speakers were particularly concerned with the quality of relationship they perceived they had with their doctors. Issues such as 'trust' and 'respect' were described as desirable. In McCoy's study some participants talked about trusting the doctor's expertise or motives, but here trust also seems to connote the ideas they had about expectations of the doctor's possible response to the issues they raise: It refers to their belief that the doctor will not 'brush them off' or belittle them. In the second quotation, the speaker makes a similar point and describes the key element as 'a respect' which, if it is evinced by the doctor, makes him feel comfortable, and the sense of disapproval which has accrued from many authority figures in the past will be less stultifying. McCoy believes that in this context respect is the 'flip side' of trust: 'trust is what patients feel and do when doctors feel and express respect' [33, p. 798].

Now, from the point of view of our interest in brief communication, what it interesting here is that the first participant links his ability to 'trust' to the practitioner not acting 'aloof' or superior. Perhaps the interactional sense of solidarity and reduction of social distance is a component of this sense of respect. From McCoy's account it seems to be something that can be cultivated relatively quickly. In terms of Brown and Levinson's [34] notion of 'politeness' it creates a sense of involvement or belonging in a group, which addresses the desire to be 'ratified, understood, approved of, liked or admired' [34, p. 62]. Moreover, the quality of respect is detectable readily and rapidly by clients and is associated with greater and more cordial exchanges of information [35].

4. 'Time tardises' and indexicality

Managing limited time and ensuring that the patients or clients get the best out of the encounter, no matter how brief, is increasingly essential for health care workers. One idea, which is all the more interesting because it intersects neatly with a key concept from ethnomethodology, is that of the 'time Tardis'. The concept originates with an Australasian colleague, Wendy Hu. Like the Tardis in the popular science fiction series 'Dr Who', the encounter needs to be bigger 'inside' than it looks from the 'outside'. Part of this process involves 'housekeeping factors' such as preventing the phone from ringing and colleagues from interrupting so as to create a sense that one is focusing on the client.

Some clinicians with resources at their command and assistants can use two consulting rooms so that an assistant can 'greet and seat' the client in one room whilst the practitioner is finishing off the previous consultation in the other and then stride into the room and begin the consultation immediately, whilst the assistant is showing the previous client out and the next one in, thus minimising the 'dead time'. On the other hand, if one is working single handed, a great deal of useful information can be gauged from watching the patient walk into the consulting room and take a seat. This can also be the occasion for a little thinking time for deciding how best to approach the situation. The client's demeanour can yield clues as to whether they are downcast or walking with difficulty. Whether they respond to a smile and greeting can yield valuable clues as to the likely work needed to establish rapport. A consultation where the practitioner is seen by the client to be caring and attentive need not be a long one. Anecdotes from practitioners and patients describe half hour consultations which did not yield a sense of satisfaction, whereas warmer, better focused 5 min ones did so.

To makes sense of this let us draw on another important strand of work in sociology and linguistics that helps to explain how some interactions can imply a great deal more than is actually made explicit. A key idea that is particularly useful is that of 'indexicality', which is seen as a 'method' that individuals employ in creating a sense of intersubjective understanding [36–38]. The term is summarised by Leiter [38, p. 107] in the following way:

> *Indexicality* refers to the conceptual nature of objects and events. That is to say, without a supplied context, objects and events have equivocal or multiple meanings. The indexical property of talk is the fact that people routinely do not state the intended meaning of the expressions they use. The expressions are vague and equivocal, lending themselves to several meanings. The sense or meaning of these expressions cannot be decided unless a context is supplied. That context consists of such particulars as who the speaker is (his biography), his current purpose and intent, the setting in which the remarks are made, or the actual or potential relationship between speaker and hearer.

Within the ethnomethodological tradition, indexicality is not something that individuals find in their environment, and that it is

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not quite the same as 'world knowledge', 'context-sensitivity', or 'situation'. The kind of context is something that the individuals construct between themselves so as to establish the meaning of what is being said. This kind of construction can proceed very rapidly. Garfinkel [36, p. 25] claimed that 'for the purpose of conducting their everyday affairs persons refuse to permit each other to understand 'what they are really talking about'', because often it is too tiring, time-consuming and difficult. Indexicality allows utterances to represent considerably more than is said and thereby makes mundane conversation possible.

An example of this phenomenon, where the cultural associations and indexicalities of terms are brought into alignment occurred in a study the authors were involved in a few years ago concerning interactions between callers to the UK's NHS Direct telephone helpline service [39]. A caller had described a problem with her ear for which she had visited her GP and with which she was seeking reassurance. Unusually, as NHS direct is a nursing-based service, she was speaking to a doctor:

Caller: [. . .] he made it sound quite scary. He's made it sound like my my my ear was going to explode or something.

Doctor: That's always a possibility, that the eardrum does burst if it were if that were to happen

Caller: Em

Doctor: It's just the infection they usually heal anyway

Caller: Yeah

Here the possible indexicality of an ear infection is renegotiated. The potentially catastrophic aspects of a burst eardrum, with implications of hearing loss and permanent injury are effectively downgraded. The worst case scenario is headed off with an 'if' statement leading to the assertion that it is 'just' the infection and that healing will usually take place. Thus, the source of concern is downgraded. More speculatively, we could see this as being part of a system of emotional management too, of the kind identified in studies of emotion work in health care which we have reviewed above, and in health care professionals and their commentary on symptoms.

This relies upon judgements and values which are 'naturalised' and socially shared. Indeed one can see the process of using allusive terms which are rich with indexical possibilities as being fundamental to creating space within a relatively condensed encounter.

In making sense of the indexicality of a statement, a good deal of everyday, commonsensical – and arguably shared – knowledge is involved. This is also true for researchers. Garfinkel [36, p. 77] intimated that when engaged in an investigation, researchers can only make sense of the phenomena under study by drawing on background cultural knowledge. People making sense tend to embed the particular instance in front of them in their 'presupposed knowledge of social structures', attending to the sequence of action which unfolds, and waiting for patterns to emerge. The phenomena or patterns that observers see remind them of what has gone before, and the reflexive relationship between past and present helps to contextualise what is happening now, and enables us to predict the future development of a course of action. This reliance on shared meanings can enable relatively brief fragments of conversation to mean a great deal and can, if used judiciously, enable practitioners and clients to conjointly create 'time Tardises' in relatively brief clinical encounters.

The terms we use, then, are rich with culturally encoded shared meanings. Sometimes the indexicality of the concepts used and their connotations creates opportunities for upset too. Indexicality is clearly not always about embellishing the encounter with positive connotations or establishing rapport. Diagnostic terms sometimes carry an almost unbearable weight for the recipient. This was first demonstrated a generation ago by Baruch [40] in his work on parents' accounts of encounters with healthcare professionals concerning their child's disabilities. There were descriptions of conflict and encounters which were at cross purposes, recounted as 'atrocity stories'. Thus, irrespective of the interactional tenor of the encounter itself, clients may subsequently discover that their recollections of it are distressing or annoying.

Many of these recollections of unhappy encounters condense the point of contention into a single incident or even a single phrase. A relative of ours repeatedly recalled an encounter with an orthopaedic specialist whom she was consulting about musculoskeletal pains. On disclosing that she was using a popular brand of painkiller known to contain caffeine he had apparently responded 'Oh, a caffeine addict eh?' Despite her annoyance at this comment which persisted over several years, she had not challenged this at the time.

The idea of some kinds of brief encounter leaving patients or their families upset is revisited frequently in the literature. Consider this quotation from a semi-autobiographical research study by Green [41, pp. 804–805] who discusses the experience of having a child with disabilities:

> The diagnosing physician is almost universally seen by parents as impossibly distant from their emotional reality. . .In our case, Amanda's 'life sentence' was pronounced by a paediatric neurologist we had never seen before in an office visit lasting less than 20 minutes and punctuated by several routine telephone calls and messages regarding other patients. The life stories we had imagined for ourselves and our daughter were obliterated with a few simple words delivered without any sign of emotion: 'has anyone told you that your child has cerebral palsy? No, well that's what she has'. We were assured that 'at least she's not retarded - her head's the right size', and sent on our way armed with a one-page handout of textbook medical definitions - most of which had nothing to do with cerebral palsy and none of which had anything to do with our pain.

This story, incorporated into an academic account of the care process, highlights a number of factors. Not only do we have the usually unhappy account of being told a 'bad news' diagnosis, but a number of aspects suggest even less propitious circumstances. 'Has anyone told you' alludes to the fragmented nature of the care, and the possibility that the health professionals have known for a while but merely not disclosed the diagnosis. The supplementary information 'at least she's not retarded' and information sheet are felt to have increased rather than decreased the burden, and hint ominously at more dire possibilities. The indexicality of the diagnostic terms and the circumstances surrounding the disclosure then spread out beyond the encounter to affect the lives of those concerned over and above coping with the child's physical disabilities.

In Green's case, of course, we do not have access to a record of the actual encounter. What is significant however is the sense of grievance which persists. This highlights the value of addressing the study of these brief communications via multiple methods, exploring both talk in interaction and ethnographic data concerning clients' and clinicians' perceptions and life circumstances before and after the communicative event in question.

There are of course a variety of documented techniques which ameliorate diagnostic news and which may themselves be so speedily expedited by experienced clinicians that they might easily pass unnoticed. Perhaps the best known of these is Maynard's [42] 'perspective display sequence'. Maynard's examples come from clinics which specialise in disorders of childhood like autism and

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developmental disabilities. Children were assessed and then clinicians met the parents to discuss the nature of the child's problems. As clinicians introduced their findings and recommendations to the parents they often asked parents for their perspective on the child, and incorporated this into their account of the child's difficulties. These perspective display series involved (1) the clinician's query or perspective display invitation to the parent, (2) the parent's reply or assessment and (3) the clinician's report and assessment. Clinicians tend to fit their diagnostic news delivery to the occasioned display of the parents' perspective, especially by formulating agreement in such a way as to co-implicate the parents' perspective in the diagnostic presentation. Thus, by means of this brief manoeuvre, the potentially distressing news is more agreeably tailored to the parents' point of view.

From the patient's perspective, the key events in their medical narrative may be condensed into particular brief encounters or even individual phrases or aphorisms. These may be recounted as part of the 'atrocity stories' identified by Baruch [40] or may be part of a more subtle process of unpicking or repairing the hurt.

One of Green's informants describes a brief yet hopeful encounter with a clinician, some time after receiving the initial diagnosis.

> To this day, I thank this one doctor in the hospital because. . .he pulled me aside and he said: 'you know you're hearing a lot of negative. . .I want to show you another case. . .' He showed me this one little boy that he had. . .delivered eight or nine years before. He had a picture of the kid's brain scan and it was very similar to (hers). . .He said: 'Just get involved as soon as you can with therapy and preventative type things and you'd be surprised. Don't ever let anyone tell you that that child can't do anything. You just bring her home and treat her as normal as possible and don't protect her. Don't baby her. Let her do the best she can do because that's the best you can do for her as a parent'. Then he showed me a picture of this boy when he was eight or nine years old and he was playing baseball and I was like: 'Oh, yes!' [41, p. 809].

The process of picking apart the negative connotations of diagnostic labels is addressed by the doctor in this transformation tale, and is adroitly undermined in a deceptively ordinary gesture of telling a story about another patient. This illustrates the kinds of processes that we have been discussing throughout this paper. This account is reminiscent of something Denzin [43] says is a powerfully entrenched part of the autobiographical storytelling form. That is, the notion that lives are turned around by significant events which Denzin calls 'epiphanies'—'interactional moments and experiences which leave marks on people's lives' [43, p. 70]. Whilst our access to these moments is often through retrospective accounts, such as that of Green's informant, they are frequently ornamented with an acutely presented event or saying. This is central to the notion of brief communication. Whilst events like these look ordinary, they are filled with interactive work which is much more subtle and complex, and may leave lasting positive impressions.

5. Phatic communication, personal details and small talk

Such everyday matters as greetings and goodbyes, thanks and compliments are aspects of phatic communion that enhance social cohesion. Laver [44] argues that the phatic function of actions such as compliments is a 'propitiatory' or emollient one. To make small talk or extend greeting exchanges defuses 'the potential hostility of silence in situations where speech is conventionally anticipated' [45, p. 301]. 'Passing the time of day' or 'shooting the breeze' help us to manage the mood of others and enhances amicable relations, which Burnard [18] argues is especially important in mental health settings.

Whilst it is not easy to draw exact parallels between healthcare encounters themselves and the meanings which the participants subsequently ascribe to them, there are some intriguing attempts to explore what these might look like in practice as researchers explore brief yet biographically pivotal events. Barton [46, p. 32] provides this sample from a patient and doctor discussing whether the patient should participate in a trial of a novel cancer treatment:

> Ms G.: Let me ask you what I consider an important question. Are you married?
>
> Dr. T.: Yeah.
>
> Ms G.: If it were your wife, would you have her do this, if she had my cancer?
>
> Dr. T.: I'd have her try.
>
> Ms G.: What if it was your mother, because I don't know the relationship you have with your wife [laughter].
>
> Dr. T.: I would encourage her to at least try. I would be disappointed if I honestly didn't get the [drug], but that's the other standard. You don't get anything anyways, so there's no losing to me. (Ms G.: family)

This illustrates, says Barton, an event of the kind where patients are reluctant to make up their minds by themselves and seek advice from the doctor as to the best decision to make. Yet at the same time, it affords us the chance to examine part of the pivotal moment of deciding whether to enter a trial. What is also interesting is that this departs from what is supposed to be the conventional format of doctors' talk, and instead involves the doctor talking about personal matters concerning hypothetical situations involving family members. Although personal talk in healthcare has often been considered secondary to serious matters of diagnostic work and decision making, examples like this show that these brief apercus from the personal realm are likely to be important markers of profoundly consequential decisions in patients' lives and which as Barton notes are becoming more important as ethical developments place more decision making responsibility in the hands of patients.

This turn to the personal dimensions as a focus of inquiry in health care studies has seen researchers beginning to explore communicative situations other than the bedside or consulting room. For example, Long et al. [47] have begun the process of mapping out 'corridor conversations' in hospitals and have argued for its importance in facilitating the clinical workflow. These 'corridor conferences' and fleeting examples of 'hallway medicine' are gradually being brought within the canon of health communication studies.

It is apparent that in much of what we have styled 'brief communication' there is a curious mixture of personal and technical, as well as phatic and informational elements. It is the kind of talk which has typically slipped beneath the radar of health care professionals and educators. As Coupland [48, p. 6], says of small talk:

> in professional and commercial domains, small talk needs to be interpreted not only in terms of its relational function (establishing rapport between professionals and clients), but in terms of how that rapport furthers or contests the instrumental and transactional goals of the institutions.

Indeed, there is increasing acknowledgement of how difficult it is to know exactly where to place the distinction between the relational and the transactional aspects of a conversational

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exchange in institutional settings [49, p. xv]. Goffman [50, p. 508] said: 'what talkers undertake to do is not to provide information to a recipient but to present dramas to an audience. Indeed, it seems that we spend most of our time not engaged in giving information but in giving shows'.

6. Discussion and conclusion: the opportunities for brief communication

6.1. Discussion

In this paper we have outlined some of the difficulties that arise in communication between practitioners and patients where pressure of time may be a factor. Additionally we have outlined a variety of theoretical perspectives, research studies and practical strategies whereby brief opportunities for communication may be rendered effective in improving the experience of health care for patients, carers and practitioners. There is considerable value in developing ways of thinking about the brief opportunities for communication which may enhance health care encounters for both patients and practitioners for this will enable the development of research and practice so as to optimise the brief encounters of contemporary health care. Despite their fleeting quality, these are important for as Bourdieu argues 'narratives about the most 'personal' difficulties, the apparently most strictly subjective tensions and contradictions, frequently articulate the deepest structures of the social world and their contradictions' [51, p. 511]. To make sense of what a client gains from a health care encounter where they feel they are being listened to, respected or taken seriously and that their fate matters to the health care professional demands a research agenda that attends to the health care system and the culture within which they are embedded as a whole.

6.2. Conclusion

We would argue that these brief encounters and their accompanying subjective feelings can be understood through the application of insights from linguistics, sociology, social psychology and anthropology. As well as research perspectives, these disciplines give us some conceptual and practical tools to begin to enhance the positive potentials of brief communication which we have detected, and attempt to ameliorate the negative impact. At the same time, the epiphanies of reassurance recounted by some clients highlight the power of brief personal asides to inculcate hope. Such cases underscore the need for practitioners to be judicious lest this flush of optimism result in disappointment later. Grasping the significance of emotion work or sentimental work, and appreciating how language can mean very much more to interactants than the dictionary definition of the words, via concepts such as indexicality, can contribute to researchers' and practitioners' ability to enhance communication with clients.

6.3. Practice implications

The fact that brief communication is often informal, and is necessarily transient, means that despite our suspicion that it is important, its characterisation requires a challenging and complex research agenda. To fully appreciate the role of brief communication researchers need to move out of the temporally and spatially bounded confines of the consulting room into corridors, cafes and communal spaces, and further rapprochement is necessary between the strands of inquiry which elicit participants retrospective accounts on the one hand and those that provide detailed, real-time explorations of the encounters themselves. It is only by combining these two approaches that the full significance of these brief encounters can be explored and exploited.

Toffler's [1] vision was that in the future large scale mass manufacturing would dwindle and instead a kind of 'recipient tailoring' would come to predominate in industrial production. The vision of brief communication and its potential that we have attempted to outline here is similar. Perhaps the brevity of so many healthcare encounters means that increasingly clinicians will have to move away from the large scale 'people processing' [52] and towards a communicative health regimen where participants are attended to individually. Despite their fleeting and transient quality, it may be that the aspects of brief communication we have outlined here can play an increasing role in health care as the brief encounter is elaborated into the art form it should surely be in tomorrow's health services.

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