

Politeness strategies in question formulation in a UK telephone advisory service

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Abstract

Politeness is of particular importance in health care contexts, where a number of international agreements and consensus statements formulated by policy makers demand that accord should be maintained, agreement should be solicited, and an attitude of respect be sustained especially when burdensome or intimate matters are being discussed. This paper explores the patterns of politeness in a corpus of material from a UK study of telephone encounters between NHS Direct health advisers and callers presenting with a need for advice over medication. In the opening sequences of interaction the questions that advisers asked the callers often included multiple politeness markers, for example through terms such as “may” and “just”, as in “may I just ask you?”. Politeness markers were often multiply layered, falling into three part structures which occurred when mundane information such as callers’ names and telephone numbers were being elicited. Where more intimate matters were at stake, advisers minimized imposition and, arguably, undertook rapport building by means of preambles to the question such that the impending intrusion is accounted for, explained or mitigated. A potentially problematic question could also be followed up by further relational work and humour. There are important implications here for understanding politeness itself, especially where it is displayed by an institutionally more powerful or symbolically credentialed interactant towards one who is less advantaged.

Keywords: tele-health, call-centres, politeness markers, habitus, relational work

1. Introduction: Politeness in health care

A good deal of human communication, especially in health care contexts, is governed by interactional processes which have been addressed through politeness theory (Brown and Levinson 1987). En-

counters in health care have been identified as crucial sites for intervention by policymakers, educators and practitioners seeking to make them more humane and effective. There are several international agreements and consensus statements promoting communicative improvements (Simpson et al. 1991; Makoul and Schofield 1999). One such, the Kalamazoo consensus statement (Brunett et al. 2001), emphasizes the need to understand the patient's perspective, share information and reach agreement. Curiosity about how this is accomplished means that students of the health care encounter, educators and politeness researchers have a number of common concerns.

This paper will address some of these concerns through a study of the NHS Direct service, said to be the world's largest telephone helpline service (David 2005) and which plays a pivotal role in the provision of out of hours care in the UK (Comptroller and Auditor General 2002). Early in its development, much of the research on the service focused on the medical quality of advice delivered and on the economic and health benefits of the service. Factors were investigated such as whether the advice was followed (Foster et al. 2003; Byrne et al. 2007), whether the different computer-aided assessment systems yield different outcomes (O'Cathain et al. 2003), the quality of the customer satisfaction achieved (Florin and Rosen 1999), value for money (George 2002), or the role NHS direct played in the overall system of care (Munro et al. 2000; Nicholl and Munro 2000). However, in the early days we knew relatively little about the "terra incognita" of the consultations themselves which took place within it.

More recently, detailed study of this body of health-related communication promises important insights for language study as well as yielding practical outcomes for practitioners, policy makers and health educators as well as patients themselves (Adolphs et al. 2004; Goode et al. 2004). In practical terms, for the improvement of services and education for service providers, interested parties in the UK are keen to examine whether the advisers, nurses and doctors are delivering the service in a thorough and rigorous yet courteous and sympathetic manner. In the longer term, it will be useful in facilitating theoretical development as part of broader research projects to examine how we talk about health and illness as a community of sufferers and healers.

2. Face, politeness and capital: Theoretical approaches

As we have suggested elsewhere (Crawford and Brown 2002), the consideration of interaction rituals in health care can be illuminated by Goffman's (1967) account of face-to-face interaction. He argued that the ritual actions in everyday life often centre on protecting "face", or

"territories of the self", expanding the ethologists' concept of territory to include areas of visual, verbal and informational privacy (Roth 1995: 317). In Goffman's (1967: 19) words, "one's face is a sacred thing, and the expressive order required to sustain it is therefore a ritual one". He goes on to state that "When a face has been threatened, facework must be done" (1967: 27), demonstrating how the self is "a ritually delicate object" (1967: 31). Whilst Goffman promoted the notion of face as a social construct, Brown and Levinson (1987) subtly reformulated it to emphasize interior, personal qualities and the pre-existing needs which interactants bring to the encounter.

More recently, there have been concerns that the preservation of face is not the sole or even the most important function of politeness (Watts 2003). Watts maintains that Brown and Levinson provided a theory of face management rather than politeness and instead promotes the notion that politeness is a "politic" practice. Behaviour may be "politic" if it meets the criteria of politeness outlined by Brown and Levinson but does not appear to the interactants to be particularly polite or impolite – it is merely situationally-expected practice. A growing consensus has been taking shape to the effect that we cannot readily decide which actions are polite or impolite in advance, but instead these are determined by the people interacting in a particular cultural setting. Analysts' intuitions as to what is polite or impolite may not correspond to the views of participants themselves (Eelen 2001). Eelen (2001: 257) argues for "a turn towards a firmer embedding of politeness within the dynamics of social reality".

Harris (2003) argues that the institutional context is often neglected in politeness research, and that politeness is seldom considered in studies of institutional conversational order. She advocates study of the wider organized forms of social activity within which instances of politeness and impoliteness are embedded and exemplifies this through accounts of politeness in the courts, police and health services. Eelen (2001) suggests that the interplay between social power and politeness can serve as an argumentative social tool for establishing identity (2001: 224–227). This is aligned with the idea of relational work proposed by Locher and Watts (2005: 10) to denote the "work individuals invest in negotiating the relations with others".

To explicate the resources which individuals may use in undertaking such work, Watts draws on Pierre Bourdieu's (1977) notion of habitus in the sense that interactants bring to the situation a "set of dispositions to act in certain ways, which generates cognitive and bodily practices in the individual. The set of dispositions is acquired through socialization" (Watts 2003: 149). These acquired dispositions embrace culture, imagery and historically predisposed means of understanding the world as well

as patterns of action and conduct. A good deal of this may be barely conscious, or what Bourdieu calls *le sens pratique* – the intuitive “know-how” designating the embodied, involuntary understandings of social life that are not always cognitively perceived (Bourdieu 1990: 66–69). Habitus involves the “power of adaptation” and offers a way of understanding individuals as a complex amalgam of their past and present which is always in the process of completion and therefore open to change (Bourdieu 1993: 88). To those seeking a means of making sense of how a particular face is deployed consistently by a cultural group, Bourdieu’s work has proved attractive (Ostermann 2003) and offers a means of understanding how occasioned, interactive practice structures a person’s world and their place in it (Murray 1990; Stokoe 1998).

From the point of view of communication in health settings a further construct of relevance is the notion of capital, which denotes the resources available to people in this negotiation of social life. Capital can take a number of forms: economic, cultural, social and symbolic (Bourdieu 1990). From our perspective, symbolic capital is of particular interest and includes such resources as prestige, authority, and charisma, and, importantly, the legitimate ability to define situations and the possession of expert knowledge (Hallett 2003). Linguistic capital is a further variant of cultural capital and involves the mastery of and relation to language (Bourdieu 1990: 114), and represents particular ways of speaking to which value attaches. Bestowal of symbolic power may be done formally, perhaps through the conferment of qualifications, or unknowingly, unwittingly or unthinkingly by all parties in the moment to moment workings of the situation in which they are embedded. Indeed, Bourdieu contends that symbolic power relies on the complicity of both subordinate and superior actors in a field. Through a process of “misrecognition”, they can come to believe that their positions are simply part of the natural order of things (Bourdieu and Wacquant 1992). Thus it is that health care encounters typically embody an orderliness tied to the understanding that the health care practitioner has expertise and some prerogative to define what is wrong (Stokes et al. 2006). At the same time, in Goffman’s terms, one of the tasks of the practitioner is to choreograph a kind of diagnostic ritual where information is elicited from the client so as to preserve this symbolic order. Thus, potential conflicts between protecting accord and asking questions are managed through a variety of communicative devices such as disclaimers. For example Brown and Drugovich (1989: 1) discuss mitigating manoeuvres such as saying “some of these questions might seem a bit silly” in administering standard diagnostic interviews.

Telephone health advice is a particularly interesting topic of study from the point of view of politeness phenomena because so much of the

encounter hinges upon what is said. Unlike face-to-face health care, the interactants are not bound together in a particular spatial location. Key information which interactants might normally deduce from non-verbal communication and transient facial expression are missing. Therefore the persuasive quality of language and its investment with cultural capital is of particular significance in ensuring its social effectiveness. For, as Bourdieu (1991: 77) writes, speakers “most often unwittingly and without expressly seeking to do so, try to maximize the symbolic profit they can obtain”.

In the case of NHS Direct, the usual experience is for callers to make an initial call to the organization and speak to an adviser who is generally not a health practitioner who will solicit details of the person and the problem and then at a later stage a practitioner – usually, but not exclusively a nurse – will call back and undertake a more extensive assessment of the problems and suggest courses of action. This therefore means that a task faced by NHS Direct staff is to elicit information whilst minimizing potential intrusion. In addition, whilst maintaining a focus on individual need in the initial conversation, the adviser often has to inform the caller that they will have to wait in order to receive attention.

3. The NHS Direct corpus: Methodology

The data discussed in this paper derive from a series of calls made to the UK’s NHS Direct service as part of a “mystery customer” style service evaluation study. The initial agreement between the researchers’ host university and NHS Direct called for a study to evaluate the service in terms of the quality of interaction sustained between callers and advisers. NHS Direct call centre staff members were informed about the study by their line managers and all agreed to participate. Whilst a different sample of material, recorded from interactions between staff and members of the public might have the advantage of greater “naturalism”, considerations of voluntary participation and confidentiality precluded this in this instance. The present study thus positions the researchers in a manner similar to that described by Roberts and Sarangi (2003) exploring the oral examinations in medical training, inasmuch as our work meshes with and arose from the concerns of health care institutions and providers and involves a process of translation between different professional and institutional groups. Participants were given opportunities for discussing matters with the researchers prior to the study’s commencement. We understand that this kind of evaluation was relatively commonplace because NHS Direct conducts regular internal audits of service in terms of the accuracy and safety of advice giving. Whilst the staff

were aware that the study was taking place they did not know which of the calls were being recorded for incorporation into this corpus, nor were they informed of the kind of problems which would be presented. In order to reduce the likelihood of staff guessing which were the research calls, these were undertaken during busy periods at NHS Direct (9am to 11am and 6pm to 8pm). The calls were made from a number of different telephone numbers and addresses across the UK Midlands.

Compared to interaction outside institutional settings then, in this context there is a degree of "artificiality" involved at several levels. The advisers were responding to screen prompts and written materials in order to ask questions and dispense advice. The callers were presenting contrived problems. Nevertheless the data merit further study. First, because this kind of investigation represents an increasingly common form of health care research, especially where service evaluation is undertaken (Thornley et al. 2006; Benrimoj et al. 2008) and thus represents an important sphere of inquiry for applied linguists and politeness researchers in its own right. Second, because it is the advisers' politeness strategies which we are focusing upon and they were unaware of which calls were being studied, this is more likely to be commonplace in their routine call handling.

In this small scale study, the data comprise seventeen calls made to NHS Direct staff by a similar number of both male and female callers. The health problems described by the callers covered a wide range of illnesses and predominantly centred on medication advice. This topic was chosen by the research team in consultation with NHS Direct clients so as to elicit both routine screen-prompted assessment and more specialized problem solving using other materials and information to hand in the call centre office. The theme of advice on medication effectiveness and side effects was also selected to ensure a degree of conceptual coherence and comparability between the different sequences of interaction elicited. The callers improvised their performances based on a pre-agreed script with essential features such as age, occupation, place of residence and the nature of the complaint. These were also designed so as to sample a range of ages and social statuses, from a young homeless man, through to a range of manual and white collar workers from a variety of backgrounds. An initial selection of scripts was developed by a nurse academic (PC) to mimic the kinds of problems a nurse involved in telephone or walk-in advice work might encounter. These were further refined through a process of consultation with NHS Direct employees not involved in the study who commented on them and recommended revisions for authenticity, and a similar process by nurse lecturers at the host university, including those involved in developing similar scenarios for examining nurses on a nurse prescribing course. In this way the scripts

were developed to reflect both experience and educational practice, and the emerging consensus on best practice in so called "pseudopatient" studies (Benrimoj et al. 2008).

The health advisers and nurses who took part would initially be asking questions and responding using the NHS computer-aided assessment system (O'Cathain et al. 2003). This system would prompt them to ask questions in a sequence which guides the professional through a decision-making system to enable a thorough assessment to be conducted and a safe course of action to be decided upon.

Overall, the interactions reported here amounted to 61,981 words just over half of which (35,014 words) were originated by the NHS Direct staff. Whilst this is a relatively small body of data, it is also relatively specialized and coherent and will suffice as a preliminary vignette into the kinds of politeness phenomena which may be evident in the thousands of hours of NHS Direct interaction which take place each year yet which has hitherto not been available for scrutiny.

In the exposition which follows, we will present the kinds of politeness phenomena which are evident at different phases in the sequence of interaction. We will begin with the opening parts of the conversation where details are taken, and move on to some of the tasks undertaken in assessment of the health problem presented before considering strategies of advice giving. Extraction of politeness phenomena from the data set proceeded as a result of repeated reading by the researchers to create a corpus of examples which were then cohered into thematic clusters, which in this case reflect different phases in the consultation with their characteristic politeness phenomena and consideration of examples to detect their interactional features.

4. Results and discussion

4.1. Taking the details: Deploying multiple politeness markers

In the early sequences of interaction in both the initial call and follow-up consultation there are a great many examples of politeness phenomena. NHS Direct advisers undertake the task of asking a series of questions of the callers which may be perceived as tiresome, difficult or personal, and conflict with culturally-ingrained norms relating to asking personal questions of strangers. Therefore politeness phenomena are particularly crucial. The questions they asked in order to perform their role as advisers often included multiple overt politeness markers. From our point of view, there were a number of interesting features concerning how these questions were formulated.

First, in the taking of details for the records and to establish who is being spoken to, requests were framed such a way as to emphasize atten-

tion to face. The following example gives a sense of how this is done in practice: HA is the health adviser, C is the caller or “patient”:

Extract (1)

- 1 HA: [. . .] Right. What I’m gonna do just take some details of you first for our
2 confidential files
3 C: Eh ha
4 HA: if I may, and then get a nurse to call you back, it will be
5 C: OK
6 HA: Approximately around about 40, 45 minutes at the moment
7 C: OK

Here, the adviser frames the subsequent interaction but at the same time downgrades it with the modifier “just” (line 1) – as if the intrusion into the caller’s private life is minimized, an impression further reinforced by the term “confidential” a little later (line 2). After the caller has signalled conditional assent the adviser further attends to face and emphasizes the voluntariness of the ensuing requests with “if I may?”

The politeness strategies utilized at the start of the interactions often exhibited several “parts” or instances of polite terms. To illustrate what we mean, here is the opening of a call between a 24-year old woman (FP) presenting with earache and a health adviser (HA):

Extract (2)

- 1 HA: Good evening, NHS direct, you are through to Martin, one
of the advisers
2 can I begin by taking the telephone number that you are calling from please?
3 FP: A a a It’s 0151
4 HA: Yeah
5 FP: 519
6 HA: Yeah
7 FP: 7079
8 HA: Thank you. If I just can confirm that with you please?
9 FP: A ha
10 HA: That’s [City] 5197079.
11 FP: Yup, that’s right
12 HA: Thank you very much. May I take your name, please?
13 FP: It’s emm Tracey Johnstone.
14 HA: And how can I help you?

Here, in lines 1–2 the adviser says “can I begin ... please?” and in the remainder of the extract succeeds in administering twice a “thank you”

(lines 8 and 12) and two further pleases (lines 8 and 12), constituting a commonly occurring opening strategy distributed in our data. In encountering public agencies through which health and social care is administered, we might routinely expect to be asked personal details such as our name and other particulars relating to how we can be contacted. Yet despite this expectation, politeness forms proliferate at these very junctures. Speculatively, it is possible to attribute several other functions to this display of politeness as well as merely minimizing the imposition. It may be informed by the formulaic or generic structure of health care encounters (Brown et al. 2006) where a good deal of the relational work to build rapport tends to occur in the early stages of the encounter. The potential delicacy of matters which might be discussed later could occasion politeness strategies as part of the ritualized habitus to make care of the body and its dirty work manageable (Bergstrom et al. 1992; Twigg 2000). The absence of “demeanour cues” (Brown et al. 2006) or hexis (Bourdieu 1991; Hasan, 1998) means that the subsequent unfolding of the problem is even more uncertain than in face-to-face encounters and thus the politeness strategies employed may signal sensitivity to this.

Further examples of pre-sequences of politeness at the outset of questioning sequences offer a kind of framing for future interrogations. These were found throughout the corpus of material collected:

Extract (3)

- 1 HA: [...] I just need to ask you a couple of questions if I may?
2 FP: Eh ha
3 HA: Can I just ask you how you heard about our service, please?

In this example, the manifestation of politeness includes multiple requests for permission to ask a question, whose banality seems at odds with the several permissions requested: “if I may?” and “Can I just ask you ...”, which are followed with a tag “please” with rising intonation at the end. This three-part politeness structure is one which in our data occurred in the parts of the encounter concerned with the collection of mundane details, such as name, telephone number, date of birth and the source of referral.

Some further clues as to the meaning of this display of politeness in the opening of an advice-giving interaction are provided by the literature on conversation analysis applied to telephone communication. There is a substantial literature on the opening sequences of telephone calls (Hopper 1992; Schegloff et al. 2002: 16) which has now extended itself to consider openings in a variety of languages (Luke and Pavlidou 2002; Thune and Leonardi 2003). These accounts propose a set of 5 sequences:

- 9 HA: OK, so as I say I need to take some of your details.
 10 C: Eh ha

In this example not only is the course of questioning outlined but the end point specified as if to offer an "account" for the questions – a sort of justification or mutually agreeable objective, as if to head off the possibility that the questions might merely be intrusive. A further notable feature of this preparatory work before the assessment questions begin is that it is a turn taking activity and the client's turns signal agreement at each point (lines 2, 4, 6, 8 and 10). The adviser's turns, although not explicitly formulated as questions, invitations or requests, nevertheless invite responses, rather like the first parts of adjacency pairs.

Another example is provided by a 28 year old woman calling about a rash from which she is suffering:

Extract (5)

- 1 HA: Let's go through some specific questions
 2 HA: then we can em ah eliminate a few things.
 3 C: Right.
 4 HA: How does that sound?
 5 C: Yeah.
 6 HA: All right?

Here, the pre-sequence reproduced in its entirety in Extract (5) which precedes assessment questioning involves multiple solicitations of agreement – perhaps significantly in a group of three, in lines 1–2, 4 and 6. This example also used a collective form – "let's" and "we" (lines 1 and 2), as if to solicit solidarity and common interest. Here, by contrast with Extract (4), the adviser is also formulating the solicitations at lines 4 and 6 as requests which invite agreement.

Schegloff (1968, 1980, 1988) has emphasized the crucial role played by the pre-sequence in framing the transition to subsequent types of talk such as more explicit requests, offers and invitations and argues that one of the functions of the pre-sequence is to help smooth the way to subsequent agreement between the speakers. The pre-sequences presented in Extracts (4) and (5) exhibit the common feature of metalanguage in our data, in that they involve a "meta question" or question about the future questions. Therefore, an introductory pre-sequence can be used as a way of "sounding out" a particular terrain in order to avoid a potential refusal. It may also serve to mitigate an imposition or to forewarn the person being questioned so that face may be enhanced and a more advantageous line may be pursued in the answers. In the case of an invitation to answer questions about one's health status, for example, the pre-invitation sequence saves a

speaker from the potential difficult situation of presenting questions which might elicit a refusal. If these invitational pre-sequences yield a hint from the invitee that the invitation to ask questions might be turned down, then perhaps a different strategy might be employed or the potentially unanswerable questions could be avoided altogether.

4.2. *Deeper into the consultation: Minimizing intrusion and relational work*

Perhaps these kinds of politeness sequences we have described above exist to minimize the intrusion involved in eliciting personal information, build rapport and help to orient the speakers to the institutional context of the conversation. Yet the symptoms of illness are arguably more personal but these are not necessarily ring-fenced by politeness in the same way. Once the consultation has got underway, some rather different techniques are used to downgrade the possible offensiveness of certain questions. Rather than "can I just ask you ...?" a different strategy is employed to moderate potential intrusion. In an example where the caller was a woman, some screening questions were directed to the reproductive tract and it was these which were preceded by intrusion-minimizing strategies:

Extract (6)

- 1 HA: OK so the question here is do you use tampons for your period at all?
 2 C: No, I use some sanitary towels

In line 1 the adviser commences with a meta-linguistic statement about the impending question which is identified as coming exophorically from elsewhere. It is not just prurient interest on the part of the nurse, but is somehow present in the set of questions that have to be gone through, thus managing any negative connotations which might attach to anyone asking such a question. These baulks against intrusion signal that a topic which might be considered intimate is coming up. We can see a more elaborate example of this in a further exchange in another of the interactions over the question of whether a caller could be pregnant:

Extract (7)

- 1 N: Em there is a question here, any chance you could be pregnant at all?
 2 FP: God I hope not

Again, a potentially intimate or worrying question is prefaced by means of a meta-linguistic preamble which pre-packages the question as coming

from somewhere else; hence the self-referential deixis of “there is a question here”. Below, in the case of a 28 year old woman with a rash, a more elaborate example shows the process from start to finish:

Extract (8)

- 1 HA: Okay (.) What about (0.2). This might seem a strange question but we just
 2 always have to sort of find out (.) where there’s any rash (.) where the rash is
 3 coming from really.
 4 C: Mm.
 5 HA: Erm do you use tampons when you have a period?
 6 (2.0)
 7 C: Erm (1.0) y (.) Well sometimes and sometimes you know the other.
 8 HA: Okay. And there’s nothing that you’ve left in place anything like that?
 9 C: Ooh no.
 10 HA: No. Okay. (0.5) ((laughs))
 11 (1.0)
 12 HA: tut (0.2) ((laughs))
 13 HA: Some do. ((laughs)) And you
 14 C: Good grief ((laughs))
 15 HA: Yeah. It’s just that obviously some rashes ((laughs)) or you know ((laughs))
 16 Well you’d be amazed what people ring in with I’ll tell you.
 17 C: Oh right. Okay.
 18 HA: Erm it’s just we have to make sure there’s no infection coming from there.
 19 C: Okay.

Thus, the possible intrusion is headed off by a relatively lengthy preamble which signals that a potentially contentious enquiry may be coming. As well as metalanguage (“this may seem a strange question”), we can see minimizers such as “just” (line 1) and hedging (“sort of”, line 2). By these means the NHS Direct personnel are able to maintain accord and minimize potential intrusion whilst talking about intimate things or parts of the body which are surrounded by taboos. The caller, even though playing a role, responds to the question about sanitary protection with a euphemism (“the other”, line 7) and laughter (lines 10–15) to defuse the negative implications of an object having been left in the vagina. Indeed, the vagina itself is not mentioned, but the term “in place” is used instead (line 8).

As Aston (1988: 138–139) notes, sequences to introduce requests may be more likely when the request itself could be seen as difficult. If a request is particularly complex, or face-threatening, the health adviser introduces the request tentatively, in such a way as to assist the receiver in preparing a reply. As Bowles (2006) notes in relation to telephone request calls, there may be an elaborate pre-sequencing strategy or set of strategies which act as a preface to the key question. The pre-sequences in the excerpts above, as in the conversations studied by Bowles, seem to serve two functions, namely that of acceptability, or making the question potentially more acceptable to the receiver, and that of accessibility, or making the request potentially more accessible to the receiver.

In the case of the example in Extract (8) above, there was also a corresponding post sequence, involving relational work to mitigate the potential intrusiveness of the question of whether anything has been left in the vagina. Solidarity is created with the caller with “you’d be amazed what people ring in with” as if, in a further act of relational work the caller and health adviser could share confidences about the problems incurred by ordinary people.

This deployment of baulks against intrusion in relation to potentially embarrassing or intimate topics is a further aspect of the professionalized habitus of health care. In identifying the issues as having come from elsewhere, and in soliciting solidarity with the caller the health advisers are engaging in a carefully orchestrated informality so as to appear as if they are personalizing the approach and deviating from the manual or script. This effectively minimizes the potential intrusion and offers further opportunities for relationship building, which as we have seen may involve humour and a sense of intimacy in the face of the peculiarities of other callers.

5. Conclusion

This study of politeness phenomena manifested in conversations between mystery callers and NHS Direct staff has revealed several features of interest from the point of view of politeness theory and which has implications for the education of health care practitioners involved in telehealth or other electronically-mediated consultations.

The insight from Brown and Levinson’s (1987) classic work in politeness theory that, it exists to enable people to save and maintain “face” in interactions, is potentially useful in relation to these findings in that the potential imposition or intrusion of questions is mitigated. Moreover, the use of metalanguage about the impending questions – “may I just ask you?” and “this may seem like a strange question” offers callers opportunities to pursue more advantageous “lines” (Goffman 1955) in

the interaction. It could also be argued to support solidarity between caller and adviser inasmuch as the adviser formulates a relationship between themselves and the caller which enables them both to orient to these as an externally-imposed intrusion and could therefore be seen as a kind of relational work in the sense proposed by Locher and Watts (2005).

This practice of forewarning callers of the kind of experience they may expect is a further example of the kinds of habitus exhibited which inform the local orderliness of the conversation. Indeed, habitus pervades or saturates social processes (Foster 1986: 105). According to Watts (2003: 160), it can be seen at work in professionally appropriate language performances which manifest "the linguistic habitus of the individual and the linguistic capital s/he is able to manipulate" to perform the professional and institutional tasks at hand. The situationally and contextually appropriate politeness strategies exhibited here require a degree of flexibility on the part of speakers and hearers and it is therefore apposite that habitus is not conceived of as a principle that rigidly prescribes particular linguistic forms or courses of action, but instead allows some creativity to be deployed in social and linguistic practice (Scheuer 2003). It is this which grants those affecting a particular professional disposition the ability to flexibly deploy different kinds of politeness strategies at appropriate points in the conversation.

The advantage of thinking about the relationship between conversational politeness practices in these terms and questions of power and professional prestige on the other is that the notion of habitus introduces an important intervening variable. Rather than encouraging us to read off a person's status from their use of politeness strategies, this way of approaching the issue enables us to see certain kinds of politeness as being built into the dispositions, culture and training of a particular cadre of professionals, and moreover, the expectations held of them by members of the public. It is here that we can advance both our understanding of how relational work is accomplished through politeness and the implications of this for educating the next generation of health care communicators.

Appendix: Transcription conventions

| | |
|-------------|--|
| (.) | Just noticeable pause |
| (0.3),(2.6) | Examples of timed pauses |
| [...] | Words omitted |
| [city] | Words changed to protect anonymity. |
| ((laughs)) | Words in double brackets give additional information |

References

- Adolphs, Svenja, Brian Brown, Ronald Carter, Paul Crawford, and Opinder Sahota (2004). Applying corpus linguistics in a health care context. *Journal of Applied Linguistics* 1 (1): 9–28.
- Aston, Guy (1988). *Negotiating Service: Studies in the Discourse of Bookshop Encounters*. Bologna: CLUEB.
- Benrimoj, Shalom I., Joel B. Werner, Catherine Raffaele, and Alison S. Roberts. (2008). A system for monitoring quality standards in the provision of non-prescription medicines from Australian community pharmacies. *Pharmacy World and Science* 30: 147–153.
- Bergstrom Linda, Joyce Roberts, Leslie Skillman and John Seidel (1992). "You'll feel me touching you, sweetie": vaginal examinations during the second stage of labour. *Birth* 19: 10–18.
- Bourdieu, Pierre (1977). *Outline of a Theory of Practice*. Cambridge: Cambridge University Press.
- Bourdieu, Pierre (1990). *The Logic of Practice*. Cambridge: Polity Press.
- Bourdieu, Pierre (1991). *Language and Symbolic Power*. Cambridge: Polity Press.
- Bourdieu, Pierre (1993). *Sociology in Question*. London: Sage.
- Bourdieu, Pierre and Loic Wacquant (1992). *An Invitation to Reflexive Sociology*. Chicago: Chicago University Press.
- Bowles, Hugo (2006). Bridging the gap between conversation analysis and ESP: an applied study of the opening sequences of NS and NNS service telephone calls. *English for Specific Purposes* 25: 332–357.
- Brown, Brian, Paul Crawford, and Ronald Carter (2006). *Evidence based Health Communication*. Buckingham: Open University Press.
- Brown, Penelope and Stephen C. Levinson (1987). *Politeness: Some Universals in Language Usage*. Cambridge: Cambridge University Press.
- Brown, Phil and Margaret Drugovich (1989). Some of these questions may sound silly: empirical standardization versus clinical application of the Mental Status Examination. Paper presented at the Annual Meeting of the American Sociological Association. San Francisco, California.
- Brunett, Patrick, H., Thomas L. Campbell, Kathleen C. Kelly, Deborah Danoff, Robert Frymier, Michael G. Goldstein, Geoffrey, H. Gordon, Daniel, J. Klass, Suzanne Kurtz, Jack Laidlaw, Forrest Lang, Anne-Marie MacLellan, Gregory Makoul, Steven Miller, Dennis Novack, Elizabeth A. Rider, Frank A. Simon, David Sluyter, Susan Swing, Wayne Weston, and Gerald P. Whelan. (2001). Essential elements of communication in medical encounters: the Kalamazoo consensus statement. *Academic Medicine* 76: 390–393.
- Bucholtz, Mary and Kira Hall (2005). Identity and interaction: a sociocultural linguistic approach. *Discourse Studies* 7: 585–614.
- Byrne, Geraldine, Janice Morgan, Sally Kendall and Debbie Saberi (2007). A survey of NHS Direct callers' use of health services and the interventions they received. *Primary Health Care Research and Development* 8: 91–100.
- Cameron, Deborah (2000a). Styling the worker: gender and the commodification of language in the globalised service economy. *Journal of Sociolinguistics* 4: 323–347.
- Cameron, Deborah (2000b). *Good to Talk? Living and Working in a Communication Culture*. London: Sage.
- Comptroller and Auditor General (2002). *NHS Direct in England*. London: The Stationery Office.
- Crawford, Paul and Brian Brown (2002). "Like a friend going round": reducing the stigma attached to mental healthcare in rural communities. *Health and Social Care in the Community* 10 (4): 229–238.

- David, Owen John (2005). NHS Direct and older people. *Age and Ageing* 34 (9): 499–501.
- Drew, Paul and John Heritage (1992). Analyzing Talk at Work: An Introduction. In *Talk at Work*, Paul Drew and John Heritage (eds.), 3–65. Cambridge: Cambridge University Press.
- Eelen, Gino (2001). *A Critique of Politeness Theories*. Manchester: St. Jerome.
- Florin, Dominique and Rebecca Rosen (1999). Evaluating NHS Direct: early findings raise questions about expanding the service. *British Medical Journal* 319: 5–6.
- Foster, Susan (1986). Reading Pierre Bourdieu. *Cultural Anthropology* 1 (1): 103–110.
- Foster, Judy, Lynda Jessopp, and Suma Chakraborti (2003). Do callers to NHS Direct follow the advice to attend an accident and emergency department? *Emergency Medical Journal* 20: 285–288.
- George, Steven (2002). NHS Direct audited: customer satisfaction, but at what price? *British Medical Journal* 324: 558–589.
- Goffman, Erving (1955). On face work: an analysis of ritual elements in social interaction. *Psychiatry* 18 (3): 213–231.
- Goffman, Erving (1967). *Interaction Rituals: Essays in Face-to-Face Behaviour*. Chicago: Aldine.
- Goode, Jackie, Gerard Hanlon, Donna Luff, Alicia O’Cathain, Tim Strangleman, and David Greatbatch (2004). Male callers to NHS Direct: the assertive carer, the new dad and the reluctant patient. *Health* 8: 311–328.
- Hallett, Tim (2003). Symbolic power and organizational culture. *Sociological Theory* 21: 128–149.
- Harris, Sandra (2003). Politeness and power: making and responding to “requests” in institutional settings. *Text* 23: 27–52.
- Hasan, Rukqaiya (1998). The disempowerment game: Bourdieu and language in literacy. *Linguistics and Education* 10: 25–87.
- Hochschild, Arlie R. (1983). *The Managed Heart: The Commercialization of Human Feeling*. Berkeley, CA: University of California Press.
- Hopper, Robert (1992). *Telephone Conversations*. Bloomington: Indiana University Press.
- Locher, Miriam A. and Richard J. Watts (2005). Politeness theory and relational work. *Journal of Politeness Research* 1 (1): 9–33.
- Luke, Kang Kwong and Theodossia Pavlidou (2002). *Telephone Calls*. Amsterdam: John Benjamins.
- Keating, Elizabeth and Maria Egbert (2003). Conversation as a cultural activity. In *A Companion to Linguistic Anthropology*, Alessandro Duranti (ed.), 169–196. Oxford: Blackwell.
- Makoul, Gregory and Theo Schofield (1999). Communication teaching and assessment in medical education: an international consensus statement. *Patient Education and Counselling* 37: 191–195.
- Morand, David A. (2000). Language and power: an empirical analysis of linguistic strategies used in superior-subordinate communication. *Journal of Organizational Behavior* 21: 235–248.
- Munro, James, Jon Nicholl, Alicia O’Cathain, and Emma Knowles (2000). Impact of NHS Direct on demand for immediate care: observational study. *British Medical Journal* 321: 150–153.
- Murray, Kevin D. (1990). *Life as Fiction*. Victoria, Australia: University of Melbourne Press.
- Nicholl, Jon and James Munro (2000). Systems for emergency care. *British Medical Journal* 320: 955–956.
- O’Cathain, Alicia, Elizabeth Webber, Jon Nicholl, James Munro, and Emma Knowles (2003). NHS Direct: consistency of triage outcomes. *Emergency Medical Journal* 20: 289–292.
- Ostermann, Ana C. (2003). Communities of practice at work: gender, facework and the power of habitus at an all-female police station and a feminist crisis intervention center in Brazil. *Discourse and Society* 14: 473–505.
- Roberts, Celia and Srikant Sarangi (2003). Uptake of discourse research in interprofessional settings: reporting from medical consultancy. *Applied Linguistics* 24: 338–339.
- Roth, Andrew L. (1995). Men wearing masks: issues of description in the analysis of ritual. *Sociological Theory* 13: 301–327.
- Schegloff, Emanuel A. (1968). Sequencing in conversation openings. *American Anthropologist* 70: 1075–1095.
- Schegloff, Emanuel A. (1980). Preliminaries to preliminaries: can I ask you a question? *Sociological Inquiry* 50 (2): 104–152.
- Schegloff, Emanuel A. (1988). Presequences and indirection: applying speech act theory to ordinary conversation. *Journal of Pragmatics* 12: 55–62.
- Schegloff, Emanuel A., Irene Koshik, Sally Jacoby, and David Olsher (2002). Conversation analysis and applied linguistics. *Annual Review of Applied Linguistics* 22: 3–31.
- Scheuer, Jann (2003). Habitus as the principle for social practice. *Language in Society* 32: 143–175.
- Simpson, Mike, Robert Buckman, and M. Stewart (1991). Doctor-patient communication: the Toronto consensus statement. *British Medical Journal* 303: 1385–1387.
- Stokes, Tim, Mary Dixon-Woods, and Simon Williams (2006). Breaking the ceremonial order: patients’ and doctors’ accounts of removal from a general practitioners’ list. *Sociology of Health and Illness* 28: 611–636.
- Stokoe, Elizabeth H. (1998). Talking about gender: the conversational construction of gender categories in academic discourse. *Discourse and Society* 9: 217–240.
- Thornley, Tracey, Nicola Gray, Claire Anderson, and Stephen Eastham (2006). A study to investigate the extent of delivery of an intervention in asthma, in a UK national community pharmacy chain, using mystery customers. *Patient Education and Counselling* 60: 246–252.
- Thune, Eva-Maria and Simona Leonardi (2003). *Telefonare in Diverse Lingue*. Milan: Franco Angeli.
- Twigg Julia (2000). *Bathing: The Body and Community Care*. London: Routledge.
- Watts, Richard J. (2003). *Politeness*. Cambridge: Cambridge University Press.