

Title: The Construction of ‘Troubled’ and ‘Credible’ Patients: A Study of  
‘Emotion Talk’ in Palliative Care Settings

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ABSTRACT

In this article, we select two categories of dying patients, namely ‘troubled’ and ‘credible’, from two larger studies conducted in three palliative care settings. We explore how nurses construct dying patients’ moral identities, how they use emotion talk as resources to interpret patients’ behavior. A microanalysis of talk-in-action using methods of discourse analysis and conversation analysis is carried out. The strategies used for the construction of moral identities include the production of atrocity stories and emotional editing. We identify moments when emotions are made relevant in palliative care nurses’ daily practices which serve to smooth social interaction and give a voice to dying patients’ words and actions. The analysis reveals that the dying trajectory, the deteriorating emotional body and the sound mind are resources used in the characterization of the credible and troubled patient. We argue that emotion talk is significant because it reveals how nurses manage conflict and tension in talk-in-interaction.

**Keywords:** emotion talk; conversation analysis; discourse analysis, credible/ troubled patient; moral identities

## INTRODUCTION

In this article we draw from two larger studies (Li, 2002, Arber 2004), which reports how categories of troubled and credible patients are constructed in the talk of palliative care staff. Troubled patients are presented by staff as dying from a terminal disease, which makes them difficult. Such patients are presented as irritable, demanding and critical of palliative care staff. In contrast, credible patients are presented as those who are bright, mentally alert and competent people in spite of their terminal illness. Our aim is to explore how palliative care nurses make sense of dying patients' emotions in talk and how they use these observed emotions as resources to interpret patients' demeanour and behavior. Emotion work according to Firth & Kitzinger (1998) is work that is involved in the managing of emotions. It is a participant resource which is actively employed by people in interaction with others. Thus emotion work functions to manage social interaction and to achieve interactional goals such as presenting oneself as competent and caring individuals. Emotion work can be considered as business in its own right and this opens up the scene for theorizing emotion work as it is constructed through talk-in-interaction (Firth & Kitzinger 1998).

We define 'emotion talk' as an activity involving words that attribute feelings and meanings to the shared and lived experience of participants (patients and nurses). For example, the use of words such as difficult day, difficult lady, lovely, and a darling (Table 3). We explore how emotion talk constructs' patients as credible and troubled;

how this is brought off in turns at talk; and the part played by emotion talk in the construction of social cohesion, reciprocity, and identity. To achieve this, a micro-analysis of talk-in-action is carried out using methods of discourse analysis (DA), and conversation analysis (CA) (Sacks 1992a, b, c; Garfinkel 1967).

## **LITERATURE REVIEW**

### **The role of emotion talk in the construction of patient identities**

In this section, we explore the role of emotion talk in the production of moral identities in sociological and palliative care literature. For example, in a study of flight attendants in a commercial setting in the USA, Hochschild (1983) found that flight attendants had to make a conscious effort to suppress expression of feelings, such as anger or upset in order to please their passengers and by extension the airline company that they worked for. Hochschild referred to acts of concealing emotions as deep-acting. Flight attendants were also expected to express desirable emotions such as using words that express warmth, pleasantness, politeness and to smile. This was called surface acting. Surface and deep acting thus served to present flight attendants with an identity as people who are nice and pleasant and who can control their own emotions in difficult and challenging circumstances. Interactional competence therefore was accomplished with reference to the management of emotions in a commercial setting.

Using secondary interview data, Smith's (1978) in her ground-breaking study examined how K came to be defined by her friends as mentally ill and where mental illness was located in talk. She made visible the emotional resources used by Angela to construct K as mentally ill and to bring off a credible performance. Angela observed that there was something wrong with K. Angela describes how K is acting out of character, how she is definitely queer, not well and needs help such as seeing a psychiatrist. The emotional resources used by Angela is identified by Smith; for example, 'crying', 'being upset' and being 'very upset'. Angela presents a compelling case that identifies K as a troubled person, which emphasizes Angela's own rationality as someone with concrete evidence for K's mental illness. To bring off a credible account, the evidence presented 'must be seen to appear that way to anyone' (Smith 1978:27). Thus when producing a credible account one device is to draw attention away from the person producing the account towards the facts being reported. Thus the evidence that K is mentally ill is compelling as there are many pieces of evidence of this, which displays Angela's identity as someone who is a credible witness of K's troubling and deteriorating mental condition even though she is a friend of K.

The role of talk in identity construction can be found in Webb and Stimson's (1976) study of doctor- patient consultations. Patients' accounts contained vivid descriptions of their experiences. For example a patient was critical of a doctor's failure to inform or act properly in relation to a serious diagnosis. Comments were made by patients and relatives such as 'it's a hair-raising story'; 'crying hysterically or screaming' were observed.

Patients' stories contained elements of drama which constituted what Webb and Stimson (1976) called 'atrocities stories'. Atrocities stories are:

'a form of communication by which people make sense of past events. It is a means of accounting for or explaining the social world of.....doctors and patients.....in telling the story the integrity of the patient is affirmed or maintained' (Webb and Stimson 1976: 109).

Atrocities stories, told by patients, on the one hand served as a vehicle for making them appear as rational and sensible beings, whilst on the other hand, made doctors appear to have acted inappropriately, irresponsibly or insensitively. Such stories served to redress the unequal distribution of power between patients and doctors according to Webb and Stimson (1976). In this article, we demonstrate how nurses also tell a particular kind of atrocities story to re-present patients as troubled but medically-warranted individuals (Lober 1975), and also to present patients as credible, interactionally competent people who have a voice that is listened to.

In palliative care settings, the role of emotion talk in the construction of moral identities can also be located in Perakyla's (1992) ethnographic study of 'hope work' in hospitals. He showed how a reciprocal relationship was collaboratively constructed in interaction by participants. On the one hand, he argued that conversation was important in constructing the hopefulness of the situation in terms of 'feeling better' or 'getting better' for dying patients and for medical staff. He demonstrated that the identities of doctors and patients were constructed by engaging in reciprocal hope work. This involved revealing the topics that were most important for dying patients and medical staff. For

example, he observed that doctors frequently used phrases such as ‘we’ve made some very promising progress’ or ‘the situation is now under control’ to evoke a sense of hope and optimism which was very often supported by the patient within the interaction. Thus patients and doctors were working together to construct a hopeful and positive situation. On the other hand, Perakyla also showed that conversation could have a detrimental effect on participants. It could destroy the hopefulness of the situation, for example by using emotive language such as ‘past recovery’ which meant there was nothing more that could be done and served to dismantle hope.

Similarly, in a study by Hunt (1989), she examined how symptom control nurses coped with the physical and psychosocial experiences of caring for dying patients in their own homes, and how nurses dealt with emotionally charged or distressing situations through talk. She demonstrated how nurses dealt with such situations through the production of ordinariness and normality in the context of imminent death. The strategies used by nurses to manage stressful situations include four role formats: friendly and informal, biomedical, psychological and social therapy. Hunt observed that the bio-medical format was sometimes used in conjunction with the psychological format by nurses as a primary method in coping with uncertainty and emotionally-laden conditions such as pain and other distressing symptoms. The social therapy format serves to construct non-medical needs. For example, ‘if you are distressed or troubled’. Within this role format, discussion of issues such as bad news concerning the terminal phase of a patient’s illness involved several strategies. First nurses set the scene by pre-empting what was to follow, for example, nurses might tell their patients that it is a ‘serious illness’, and that the decision of what to do is ‘difficult’. This seemed to work as a ‘warning shot’ about

the seriousness of the patients' situation. However Hunt also observed that the friendly and informal role formats promoted partnership and equitable relationships. For Hunt, being friendly meant polite greetings, exchanging pleasantries, talking about the most mundane things like the weather, cracking jokes or sharing a sense of humor with patients. This is similar to Hochschild's concept of surface acting.

However, hospice patients have been found to use a protective device that is called 'not talking openly' about their condition or prognosis (Copp 1996). Patients used this form of denial-like mechanism to maintain control and to preserve self-esteem. Nurses protect patients by trying to reduce the severity of a situation in Copp's study. She concludes that both nurses' and patients' engage in a constant and mutual game of monitoring each others' psychosocial needs. In another study conducted in a hospice setting which examined how emotions were expressed through the use of metaphors, Froggatt (1995, 1998) reports that crucial to the identity of hospice nurses was the construction of a shared and intimate relationship with each other and with their patients. Containment of undesirable emotions was vital to the construction of this mutually shared relationship according to Froggatt. This view is also supported by the findings of Garnett's (2000) study of complementary therapists. This containment of undesirable emotions reflects Hochschild's (1983) work on deep acting.

### **A summary of literature review**

The role of emotion talk is an important interactional resource for the construction of participants' identities as people who are aware and sensitive of the risks involved in the dying trajectory of patients. In the contexts examined the mutual containment of

emotions served to present participants (patients, doctors and nurses) as rational and emotionally controlled people and preserved self-esteem and integrity. The suppression of negative emotional reactions is one of the important dramaturgical principles in Goffman's (1967) analysis of impression management rituals. For him, control of emotional reactions is necessary for displaying an adequate demeanour and for showing deference. In talk, participants bring emotions under their control which could be considered a form of what we call emotional editing. Emotional editing thus serves to present participants as untroubled, nice and rational people, but also present participants as being in control of undesirable emotions. Emotional editing, which we argue is a staged performance, is one that is shared and premised on professional niceness, collaboration and reciprocity in palliative care settings (Arber 2004, Li 2002, 2004).

## **METHODS**

### **The grounded theory approach**

This article is influenced by the grounded theory approach advocated by Glaser and Strauss (1967). This means that theories are grounded in and generated from naturally occurring data collected from a natural environment (in this article, two hospices and a district general hospital). Participant observation was conducted in three palliative care settings. Within the grounded theory approach, we apply the broad principles of CA to DA. This application enables us to carry out a microanalysis of talk in action by breaking the data down to reveal the activities involved in the production of troubled and credible patients. We use some quasi-statistics such as simple counting, that is to say, counting



the number of times when certain emotion words occurred in nurses' talk to improve validity and thus increase the credibility of our claims (Silverman, 2004).

We use different methods of data analysis. These include content analysis to identify emerging themes and categories; the constant comparative method consisting of the analysis of data collected in one setting, and comparing it with the remaining two settings. We use this method to test the reliability of a single phenomenon generated from one setting to see whether it is supported in the remaining two settings (Hammersley & Atkinson, 1983). Constant comparison helps to enhance contextual sensitivity (Silverman, 1997) because it aids the identification of persistent patterns and differences within and across settings and enables us to identify the features that constitute categories of troubled and credible patients in our research settings. We use theoretical sampling to select settings which are relevant to our research topic (Coffey and Atkinson 1996, Mason 1996). An inductive approach is taken to generate concepts and categories. The data is then broken down further by using the analytic tool of CA. The technique of CA enables a microanalysis of talk and provides insights into how expertise, competence and patient/professional identities are accomplished through talk in action.

### **Conversational analysis (CA) and discourse analysis (DA)**

Both CA and DA focuses on the analysis of talk in interaction (Schegloff 1997, Billig 1997, 1999). Both are linguistically oriented with the focus on the analysis of texts (Fairclough 1992). For both CA and DA then, language is the medium for interaction. Primarily, DA concerns discovering the forms and content of discourse. Forms of discourse means searching for persistent patterns of talk, which reveals how action is

done and the rules for accomplishing activities in talk (Fairclough 1992). The content of discourses refers to the discourse resources participants use for accomplishing activities in talk, such as categorizing troubled and credible patients in this article, using the rhetoric of persuasive talk (Mckinlay, Plumbridge et al. 2005).

CA developed from ethnomethodology (Garfinkel 1967; Sacks 1992 a & b).

Ethnomethodology places emphasis on the methods members use to make sense of and account for their everyday actions. Primarily, CA takes the position that our behavior is not governed by rules but that it is guided by rules of relevance. Just as Firth & Kitzinger (1998) regard emotion talk as an activity of business in its own right, so talk in CA is also regarded as an activity rather than as the pure transmission of information between two people (Garfinkel 1967). Thus CA is not only concerned with conversations in situ but also how conversation is organized in a methodical way. It is sometimes viewed as a 'method tool kit' by writers such as Garfinkel (1967), Sacks (1992a; 1992b) and Arminen (1998). CA relies heavily on tape-recorded, naturally occurring data that is transcribed. It focuses on the analysis of turn-by-turn sequences of talk. This method seeks to reveal how participants collaboratively and strategically construct their talk by reference to how it will be heard, for example, good or bad patients, class, gender, age and ethnicity. From this perspective, talk is regarded as a member's method of 'doing being-in-the-world' (Arminen 1998: 32).

CA is context bound and context renewing. This means that the previous turn produces the next context for the continuation of talk. It is through turn-by-turn analysis of talk that we are able to uncover how participants accomplish interactional tasks. For example,

CA reveals category-bound activities such as 'caring' or 'mothering'. It helps to identify 'noticings' (Gumperz, 1992). According to Gumperz, 'noticings' are the:

'unremarkable, unremarked, seen by unnoticed incidental details of daily life....some things only come to have a significance in retrospect, in the light of something which happened' (Gumperz 1992: 484)

In other words, 'noticings' refer to the things which attract our attention in our ordinary, mundane and taken-for-granted world. CA is inductive and cumulative. This means that it is data driven in the sense that generation of theories begins with the analysis of the first set of observation which determines further data collection strategies and this is also a feature of grounded theory. The saturation of data is reached when full transcripts are examined for all the categories and are considered saturated when no new categories or themes emerge. The saturation of data includes identifying deviant cases, and 'absences' which means things that are left out can be topics for investigation. Through turn-by-turn analysis of talk, we show how palliative care nurses use conversational devices such as extreme case formulations, alignments between participants, category-bound activities and contrasting devices to construct 'troubled' and 'credible' patients (Watson 1981, 1987; Clayman 1992; Bergmann 1992; Gumperz 1992). The advantages of using techniques taken from CA is that it produces reliable information and the method advances in an inductive fashion (Seale 1999, Alasuutari 1995).

There are some disadvantages when using CA to analyse data. For example everything has to be based on the material made available to the participants during conversation and explicitly referred to by the conversationalists (Alasuutari 1995). However, when used

with other methods, according to ten Have (1999), it is possible to make further observations from qualitative data, which may be used as clues in addressing social phenomena. We select two verbal interactions between nurses from two palliative care settings because:

- a) the typical features of emotion talk are reflected in the nurses' talk.
- b) the sequential accomplishment of credible and troubled patients can be identified as the talk unfolds.
- c) the extracts display the strategies used by palliative care nurses to construct patient identities.

### **Research context and sample**

For the research as a whole two hospices (H1,H2) and one general hospital (HP1), which had a palliative care service unit, were purposively selected for comparative analysis. In our research settings, most patients had a diagnosis of cancer. There were also non-cancer admissions, for example, patients with Motor-Neuron Disease, Parkinson's Disease, Alzheimer's Disease, Diabetes and Peripheral Vascular Disease. However, patients were generally at the terminal stage of their disease. The age of the patients ranged from 28 years to 102 years. Patients came into palliative care settings for symptom control, continuing care, terminal care and respite care. A total of twenty-eight palliative care staff from the three research settings were observed, and a total of 54 staff were observed taking part in the PCT meeting. Data collection stopped as soon as data saturation was reached.

## **Consent**

Permission was obtained from the Ethical Research Committee in our research settings. Information sheets for both palliative care nurses and patients were provided. These were displayed on patient's notice boards in the wards. Written and verbal consent was also obtained from palliative care nurses. The ethical guidelines of each setting were followed throughout the research. We argue that consent is not a fixed category. It was subject to constant negotiation on each occasion.

## **Methods of data collection**

Our data sampling was purposive and multi-method. Data were collected as a result of observation in H1 (35 hours), H2 (40 hours); and HP1 (63 hours). The main method of data collection was participant observation. It included: a) audio-recordings of nurses' hand-over meetings whereby one shift replaces another, audio-recording of eight palliative care team meetings b) field-work: observing and recording nurses' activities at work. This involved shadowing palliative care nurses when they carried out what they described as a round of 'giving care' to their patients, and taking part in the nursing care for some patients (20 in all), both male and female.

## **Data analysis**

The data were transcribed and imported into the QSR NUD\*IST program. A systematic

and rigorous analysis of transcribed audio-recorded data was carried out. Transcripts were repeatedly read until a sense of emerging themes or categories that might be of interest emerged. We conduct a comprehensive data treatment advocated by Mehan (1979) and Silverman (2000). This means that ‘every piece of data collected needs to be used until it can be accounted for’ (Silverman, 2000: 181). This method of data treatment thus allows for theoretical saturation (Seale, 1999).

A set of analytic categories was created (Table 1). A systematic content analysis was carried out. This comprised a line by line analysis of the data, marking moments when bits of data showing nurses talking about patients who present particular troubles for them to manage and moments when nurses and patients display their identity as competent people. Frequency tables were constructed to show the distribution rate of occurrences of categories. It helped to establish how frequent such categories occurred in nurses’ talk in one setting when compared with nurses in two other settings. The simple counting of emotive words were carried out and word count tables were constructed to show the number of times an emotive word occurred in the nurses’ talk (Table 2). For example adjectives such as ‘nice’, ‘good’, ‘lovely’, ‘sad’ or ‘difficult’, which characterize the patients’ expression of emotion (Table 3). The data were then subjected to CA analysis.

## **RESULTS**

In this section, we focus on two patient categories produced in palliative care nurses’ emotion talk, namely, ‘troubled’ and ‘credible’ patient. We show how a patient’s (P)

moral identity is constructed through talk about her emotional presentation. P is discussed as ‘difficult’ by two palliative care nurses in a hospice setting. A list of nomenclature is provided (appendix 1).

### Troubled patient

- 1 N1: P, had a bit of a difficult day with her. Doesn't get  
 2 on with her home care sister. I didn't want to document  
 3 this. She didn't want suppository, wants tablets, so that  
 4 was arranged but she changed her mind, wanted suppository  
 5 and didn't want tablets....She is a very difficult lady and  
 6 anybody will find her difficult. He daughter M was  
 7 grateful if her mother could have some counseling. She  
 8 needs a wheel chair. She did have suppository. We were  
 9 very patient\_ She looks like a dying person'.  
 10 N2: 'she tends to dramatize things. We will try social  
 11 service again. The daughter wants counseling, needs a lot  
 12 of support. She has a very stressful job. Works as a  
 13 psychologist in the prison'.

Data Extract 1 N1, N2 =Hospice Nurses

In extract 1 above, the construction of a troubled patient begins with N1 telling an atrocity story. P is giving the nurses a hard time, seen in the ‘had a bit of a difficult day with her’ claim (line 1). N1 continues to elaborate on P’s difficult and awkward behavior by listing the things P has done such as not getting on with the home care sister and not wanting the suppository and tablets (lines 2-4). Here, P’s resistance to N1’s efforts breaches category-bound expectations (Sacks, 1992a & b) of a terminally ill person. In a study of ‘good’ and ‘bad’ patients, Lober (1975) found that good patient norms concerned the degree of conformity and compliance to hospital routines and regulations. For example, good patients were those who did not complain even though they were perceived to be in pain, those who did not bother doctors and nurses, those who showed cheerful stoicism, and those who were co-operative, obedient and submissive. In the above sequence of talk, P’s refusal to do as she is told marks her as a ‘deliberated

deviant' (Lober 1975: 224). P's resistance to the nurses' efforts to help her marks her as an unpopular patient (Stockwell 1972). Thus a person who is unpopular lacks what Goffman (1967, 1976) calls *demeanour* (one who shows discretion and self control over emotions and desires) and *deference* (one who shows appreciation). Both *demeanour* and *deference* are regarded by Goffman as the rules of proper conduct. To break the basic rules of conduct may lead to the break down of social order, according to Goffman (1967).

Next we identify an elaboration of the atrocity story. P presents N1 with serious management problems. There is a threat to the social order within the hospice by her demanding behavior. The use of extreme markers 'very difficult' serves to exemplify the extent of the problem (line 5). This very difficult patient could be a threat to the competency of N1 as a caring hospice nurse. Furthermore N1 could be seen to be insensitive by criticizing her patient. This talk breeches category-bound expectations of a professional nurse who is supposed to show sympathy and a caring attitude, and who is supposed to know how to deal with this dying but difficult patient (Saunders 1990). How then does N1 deal with this potentially risky situation? In the next turn, N1 is quick to use the generalized term 'anybody' as a protective device which serves to deflect the hearable charge of incompetence from herself (N1). Thus by appealing to the generalized category (anybody), the serious charge of incompetence is minimized. Next, N1's use of extreme case formulation such as 'very difficult' is contrasted with a self-compliment 'we were very patient' (line 9). Self-compliment is presented by Li (2002) as one of the strategies for presenting the nurses as competent and nice people in talk. In this instance, it serves to redeem N1's status as a professional who might be regarded as having



behaved insensitively. This strategy further promotes N1's virtue of being very patient in the face of a very difficult patient (Lebacqz 1986).

The story continues with N1 creating the patient's and daughter's need for accessing the resource of counseling. N1 brings the membership category (Sacks 1992a, 1992b) of family (mother and daughter) into the picture (lines 6-9) which serves to produce family needs. Here, the patient's daughter appears to find her mother trying with the nurses identifying the need for counseling for mother and daughter (line 11). The link between the mother's behavior and the daughter's need for counseling is subtly achieved and succeeds in a veiled criticism of the mother's behavior (Bergmann 1992). There is also the construction of a team CV (appendix 1). At line 9, N1's talk of: 'we were very patient' serves to produce an image of professionals who are tolerant of P's awkward behavior. This is followed by the utterance 'she looks like a dying person'. The shift from a difficult, troubled person to a dying person serves to downplay the potential charge of nurses being critical of dying patient's behavior. Thus this shift serves as a protective and deflective device, which helps to safeguard the nurses' professional integrity. The moral identity of the patient as a dying patient is maintained despite her difficult and trying behavior. In this instance of talk, P's deviant behavior is perceived in a new light. The shift from difficult to dying patient serves to re-constitute P's awkward behavior as 'medically warranted' deviance (Lober 1975: 224). In this sense, this patient is exonerated, she is difficult but her credibility is maintained because she is dying. The moral identity of a caring nurse is also sustained and re-affirmed with reference to the virtue of the nurses' patience. The performance of an appropriate patient (looks like dying) and a morally responsible professional (we were very patient) enables both parties

to remain morally worthy and appropriate and credible in the circumstances presented.

Next an alignment of views occurs. At line 10, N2 attempts to present a second atrocity story about P as someone who tends to 'dramatizes things'. However, this image of drama suggests that P is in the realm of fantasy rather than rationality. The second assessment of P by N2 serves to align her view to N1's. Thus we have a shared reaction to the situation created by P as a difficult person seen in the 'we' claim at line 10. 'We' includes everyone who belongs to the same organization and it is a procedure for social alignment (Sacks 1992a). Thus 'we' is used as a procedure for making 'category bound activities' recognizable and understood by members of a particular social group. The use of 'we' involves rules of relevance. Both nurses find this patient difficult. They are in agreement and this agreement is probably shared by the home care nurse whom P is reported to not get on with (line 2). In this talk then, there is an appeal to N2's common-sense view of the world, that is, the mutual knowledge of 'typical' patients present in everyday talk. Typification in this sense means that nurses tend to unconsciously or unreflectively categorize their patients in a particular way based on their description of a patient's character and behavior (Treweek 1996). By presenting an account in a calm manner with some degree of supporting detail and the use of extreme case formulations (very) strengthens the speakers' account of events. The nurses seem to be managing the difficult performance by supporting each other in their talk. Even though a patient is troubled and difficult they can remain credible and morally worthy because of the patients' position on the dying trajectory. Thus the credible and morally worthy patient is balanced by the credible and morally worthy nurses.

In the next extract of data, a performance of credibility is sustained by the nurse and patient together. The topic for discussion is the patient P who has a diagnosis of leukemia and a squamous tumor, which has been removed from her leg and she is being treated with opioid drugs. In this extract P is constructed as a credible patient through the use of adjectives that describes her mood, demeanor and social status (Goffman 1967). Emotive terms are used to contrast the competence of the patient with the lack of competence within the care home where the patient is resident. Thus practitioners in palliative care engage in contrastive rhetoric. Contrastive rhetoric is a strategy whereby:

‘the boundaries of normal and acceptable practice are defined by institutionally and/or interactionally dominant individuals or groups through the introduction into discussion of alternative practices and social forms in stylized, trivialized and generally pejorative terms which connote their unacceptability’ (Hargreaves 1981: 320).

Thus this strategy enables the credibility of the palliative care nurses to be displayed.

## Credible patient

- 1 N1 Um. Mrs. P, she came in yesterday, did I tell you this?  
 2 N2 No. I've got a visit booked for her tomorrow.  
 3 N1 Yes that is wonderful. That's perfect. I think she thinks it's today actually.  
 4 N2 No it's tomorrow.  
 5 N1 She is a darling. She lives in that awful residential home and her daughter  
 6 lives in W College, her husband is a housemaster at W College, it is a very  
 7 nice little family. The old lady is on the ball. She's as bright as a button but she is quite  
 8 deaf and yesterday she had blood and platelets because you know she has got the  
 9 leukaemia and she has had this enormous squamous tumour lopped off so basically they  
 10 have not scooped it out. He has literally shaved it flat so it is going to come back but it  
 11 was literally like that hanging off the side of her leg in sort of pedicles, amazing thing  
 12 and they put kaltastat on. I have spoken to the district nurse this morning and I've  
 13 suggested, she said, at the moment she is on 5mg of oramorph at night which she  
 14 thinks is wonderful but she says that they can't give it to her during the day because  
 15 they are not allowed to give it. N3 says that's rubbish, so  
 16 N2 Thick as two planks over there.  
 17 N1 Yes. But what I thought might be easier, because she doesn't need 30 mg of  
 18 morphine equivalent, but I wondered if we try 10 bd of MST. So I have asked N3  
 19 to start MST morning and evening and see how she goes and bearing in mind she  
 20 might be a little bit fuzzy for a day or two because I think that will be the equivalent to  
 21 2.5 four-hourly which might be just enough. All she takes is paracetamol. Other than  
 22 that she says there is a lot wrong with her. She has got about three or four systemic  
 23 diseases you know, cardiac problems but she's totally with it and she can get about,  
 24 just about. So hopefully without this big tumour hanging on her leg she might be able  
 25 to put her tights on. She is such a sweet heart.

Data Extract 2 N1 = Hospital Palliative Care Nurse, N2 = Community  
 Palliative Care Nurse

N1 begins by telling an atrocity story about the care home and the staff who work there.

The care home is described as 'awful' by N1 (line 5), and the staff in the home are described as 'thick' (line 16). This is in contrast to the patient who is characterized as good and virtuous (Lebacqz 1986:). Virtue is 'a kind of excellence' and demands certain expectations and obligations from the patients Lebacqz (1986: 275). For example, a virtuous patient was one who managed to preserve cheerfulness and serenity of mind in spite of injuries or dying. In this instance of talk, P is described by N1 as a 'darling' (line 5), 'such a sweetheart' (line 25) and who also has a 'nice little family' (line 7). She meets the criteria of a virtuous patient. In the next turn of events, the patient too tells an atrocity story about the staff in the care home. At line 15, P is reported to have told the

district nurse (DN) that she cannot have Oramorph in the day because ‘they (the staff) are not allowed to give it’. Therefore the staff in the care home cannot give opioid drugs. Although N3 the district nurse is reported to have said ‘that’s rubbish’ (line 15), there is some confusion over whether these drugs can be given within the care home. The patient’s report is taken seriously. She is continually displayed as a virtuous person (Lebacqz 1986). She is described as someone who is ‘on the ball’ (line 7), ‘bright as a button’, even though she is ‘quite deaf’ (line 8). P has the interactional resources to present herself as a nice, emotionally balanced and a rational person. The nurses’ characterization of P contrasts with that of the care home staff who are described as ‘thick as two planks’ (line 16). In this instance of talk then, the patient is presented by the nurses as a ‘popular patient’ who fits the traditional criteria for likeability, politeness and charisma (Stockwell 1975, Johnson and Webb 1995).

The palliative care nurse N1 presents herself as authoritative in relation to management of this patient by giving advice to the district nurse seen in the use of ‘I’. For example, ‘I’ve spoken to the district nurse’ (line 12), and ‘I’ve suggested’ (line 13). The use of the inclusive identity marker: ‘you know’ (line 8) serves to produce an impression of a team-like coalition. This team-like coalition device functions to pitch N1 and the hearer against the incompetent ‘others’, that is, residential care home staff indicated by ‘they’, ‘that awful care home’; ‘over there’ (lines 5/9/16). The apparent incompetence of the care home care staff can be located in these statements: ‘they can’t give it to her’ (line 14), and ‘they are not allowed to give it’ (line 15). Their incompetence is upgraded further by N2’s utterance in the next turn: ‘thick as two planks over there’ (line 16) and N1’s utterance ‘that awful residential home’ (line 5). N1 also use descriptions of P’s mood,

demeanor and behavior represented by 'she' (lines 5, 7, 13-14) as resources to accentuate the stark contrast between the goings-on in the care home and what they consider to be acceptable and unacceptable practices.

The contrasts developed by the nurses work to enable them to construct their expertise in pain management vis a vis the lack of such expertise in the care home (lines 14-15).

Being an expert in care of the dying in terms of knowing how to control pain and other symptoms, good communication skills and good team work are important features of palliative care philosophy, work, and professional identity (Saunders & Baines 1983).

Furthermore, this construction is successful because P is also presented as a critic of the care home practice in relation to access to the drugs to relieve her discomfort (line 15).

Thus P's credibility as an 'on the ball old lady' who can communicate well with the nurses enables her report to be believed. The patient is therefore competent and credible.

The contrastive strategy that produced the credible patient/staff in the hospice and discreditable home care staff was also found in Webb & Stimson's (1976) study. For example rational/sensible patients and irresponsible/insensitive doctors identified in medical consultations by use of atrocity stories. P is also presented as having good social status because 'her daughter lives in W College, her husband is a housemaster at W College, it is a very nice little family' (lines 6/7).

In a study reported by Werner and Malterud (2003) it was observed that women patients who suffered from chronic muscular pain worked to appear credible in medical consultations. The women worked to look 'just right' such as not looking too healthy or too strong that might conflict with their disease status. 'Just right' for these women was

constructed as being perceived as somatically ill whilst simultaneously avoiding appearing mentally unbalanced. By appearing 'just right' these women negotiate and achieve their goals for the consultation by establishing their credibility in body and in mind (Werner and Malterud 2003). P is also a credible patient because she is 'just right' P is socially articulate and able to construct herself as mentally alert and bright. She uses interactional resources concerning her emotional and behavioral presentation such as appearing a 'sweetheart' and a 'darling', good social status and more importantly she is also positioned as a critic of the practices in the care home. Thus 'just right' in this context is also performed by aligning oneself as a critic of the care home practice in the same way that N2, N3 and N1 are. The social standing of the patient, her perceived credibility and brightness enables N1 to accept the patient's account of the problems in the care home. Thus talk about the emotional and psychosocial status of P, her ability to understand the work of the palliative care nurses in being able to relieve her discomfort, enables them to work as a team together in contrast to the staff in the care home.

### **A summary of findings**

In this article, we have provided a CA analysis of troubled and credible patients in nurses' talk. The analysis of data reveal the sequential accomplishment as well as strategies and sub-strategies for the production of patient categories. Credible patients are presented by staff with reference to their mental health status. These patients are also appreciative of what hospice staff is doing for them and can display their soundness of mind. The construction of credible patients in palliative care nurses' accounts reveals the qualities which are liked by nurses. Troubled patients who are difficult can be tolerated

by staff who are patient with them because they are dying. Nurses' talk reveals that patients' physical and mental conditions can sometimes lead to all sorts of troublesome behavior which may cause management problems for the nurses. Troubled patients may disrupt well-established routines. Such patients obstruct nurses' work or make extra work for them. Our findings suggest that emotion talk is important in the production of moral identities. It is one of the means that nurses use to project patients' emotional well-being and competence. Emotion talk is presented as a platform for nurses to display their qualities of caring such as being very patient and understanding with a troubled and dying patient. Emotion talk also evokes the patient as part of a team. We reveal evidence that troubled and credible patients are a co-production, negotiated between staff and patients. The strategies nurses use to produce a credible and a troubled patient are identified as the production of atrocity stories, the use of extreme case formulation, member's categorization device, persuasive device, deflective and protective device, strategic selection and editing of emotion words. These devices are summarized in Table 4.

## **DISCUSSION**

In this article, we show that talk-in-interaction is more than an occasion for the exploration of meanings, beliefs and perceptions of participants. Ethnomethodologists such as Goodwin and Heritage (1990) argue that face-to-face interaction is 'a strategic site for the analysis of human action' (p. 283). The authors argue that:

'social interaction is the primordial means through which the business of the social world is transacted, the identities of its participants are affirmed or denied, and its cultures are transmitted,



renewed, and modified. Through processes of social interaction, shared meaning, mutual understanding, and the coordination of human conduct are achieved' (Goodwin and Heritage 1990:283).

Thus the study of talk in interaction is important because it is:

'a medium for orchestration of activities through which the sense of activities is made intersubjectively available' (Arminen 1998:32).

Participants in interaction mutually engage in activities of presenting acceptable personal 'fronts' to one another. This is called impression management by Goffman (1967). He says that when individuals are in each other's presence and in the presence of others, they adopt the norms of good manners and self respect. Such individuals are conscious performers and they act out the roles expected of them within their particular contexts. In other words, the roles that they perform are scripted or staged and therefore sanctioned.

He says that such performers are:

'disciplined...someone who remembers his part and does not commit unmeant gestures or faux pas in performing it. He is someone with discretion; he does not give the show away by involuntarily disclosing its secrets. He is someone with "presence of mind" who can cover up on the spur of the moment for inappropriate behavior on the part of his team mates; while all the time maintaining the impression that he is merely playing his part' (Goffman, 1967: 190).

Individuals may control access to certain regions or certain information in contexts where they work. Sometimes we 'hide' things from another's view intentionally because they are embarrassing which Goffman calls 'dirty work'. Thus, following Goffman's (1976)

idea of impression management, the nurses in our study seek to conceal undesirable emotions by editing out those emotions that would threaten the production of a sympathetic and rational professional.

The performance of a competent and nice patient/nurse is controlled and sustained by the rules of social interaction. In Hochschild's (1983) study the flight attendants had to suppress their emotions when they were confronted with obnoxious (Davis and Schmidt 1977) passengers who sent letters of complaint (called onion letters) to airline companies. The nurses in our study also suppress their spontaneous feelings in order to achieve, sustain and smooth social orderliness by way of emotional editing. Maintaining a nice professional front and character-building are aspects of the nurse-nurse and nurse-patient relationship. In this article, nurses tried to hide their undesirable feelings in order to cultivate and sustain good impressions of themselves in settings with terminally ill people. To lose self-control or composure may reflect badly on their personal image and the image of organizations in which they work. It may also constitute professional misconduct or unprofessional behavior (UKCC, 1992). Professionals in activities of talk are careful not to blame patients for their troublesome behavior; not criticizing their patients by making excuses for them. They also take appropriate actions to minimize pain and suffering; knowing their patients; constantly watching over their patients for signs of deterioration and acting to minimize relatives' distress. This is what Li (2002) has termed a staged performance of niceness.

On the other hand, Hochschild (1983) also observed that passengers can praise flight attendants by sending orchid letters of thanks, which is appreciated by staff and makes

the job worthwhile. In Garnett's (2000) study of complementary therapy nurses who were practicing in a hospice setting, she noted that such intimate work needed to be done in the 'right manner' with the right feelings by touching and building trust. Yet it is not clear what she means by what constitutes the 'right manner'. In our analysis of the credible and troubled patients we are able to identify the strategies of telling an atrocity story that is shared between the staff and the patient, using contrast strategies and forming an alliance between nurse-nurse and patient-nurse to criticize conduct and expertise in pain management in their care settings.

The production of emotion talk allows nurses' and patients' voices to penetrate professionals' talk. In so doing, patients are made to appear blameless, untroubled and credible, and nurses are made to appear to be caring and responsible professionals. The production of atrocity stories also provides opportunities for nurses themselves to demonstrate the nature of their own expertise; and to construct implicit ideals about correct conduct and performance palliative care nurses hold in their particular social settings. Moreover, the stories allow nurses and patients to construct different versions of realities, that is to say, nurses, patient and relatives realities. These versions of reality combine to construct a plausible workable relationship which is comfortable (Jarrett 1996), supportive, reciprocal, credible and therapeutic. There is evidence from the context of palliative care that nurses avoid categorizing patients as difficult even in the most challenging circumstances (Frank 2004; Jarrett 1996). Jarrett observed that there was an absence of open disagreement between patients and nurses in her study. The participants worked to create an impression of mutual caring through avoidance of potential conflicts and emotional and upsetting events. Yet in a study by Stanworth

(2004), she found that hospice patients were resistant to the idea of avoiding difficult topics.

In this article, we have applied the tools of CA to demonstrate how credible and troubled are categories that are linked to the patient's dying trajectory and are a co-construction in staff talk. Writers such as Agar (1986); Bryman (1988) and Silverman (2001) suggest that it is not enough for ethnographers to provide a thick description of 'detailed' mundane activities though it is important and it helps to increase reliability. An application of CA may reveal some of the seen but unnoticed features of ordinary everyday talk (Sacks, 1992c). For example in Smith's (1978) study, we suggest that by applying the tools of CA it is possible to tap into the interactional resources which Angela used to construct K as mentally ill. For example, the use of moderate markers (a good student; not too bright), extreme markers ('definitely') and uncertain markers ('might be', 'I think'). These markers serve to work down K's 'normal' behavior and work up the severity of K's condition. Moreover, contrastive devices ('but') and contrastive rhetoric ('smiles very sweetly' - 'very upset') were used by participants to account for changes in K's behavior. Such devices help to locate and make visible the precise moments when K is perceived by her friends as 'becoming mentally ill'.

## **CONCLUSION**

Using a grounded theory approach and a microanalysis of talk (which includes counting) in interaction enables us to stay close to our data, avoiding the imposition of external variables into it. Our CA analysis is on a turn-by-turn basis within sequences of talk and

enables us to reveal how participants display their social understanding of their own and others' behavior. We apply the tools of CA to identify strategies in talk for the co-production of patients who are troubled and difficult and those who are credible. The emotion words used by nurses served to develop these categories. Emotion editing served to present participants as rational and morally adequate people. The criteria used by nurses to categorize their patients involved physical illness, personal pleasantness, competence, social status, strength and interest of character, and personal obnoxiousness, such as making unreasonable demands and dramatising the situation. We also explore how a particular type of patient biography such as 'making demands', 'very difficult' or 'a darling', and from which a particular kind of trouble and quality in the patient was interactionally constructed and then resolved in nurses' talk. Our findings suggest that patients may be excused being difficult because they are dying. So this behavior is located within a dying trajectory that allows patients difficult behavior to be located as morally acceptable and forgivable as they have an identity as a dying person. The talk, in this context, also enables nurses to display their patience and caring qualities.

We discuss how nurses' and patients' credibility depended on how they produced a sense of general wellness, and competence in a patient through talk about that patient's brightness and intelligence. This was contrasted with the specialist staff's criticism of non-specialist staff in the care home; who were characterized as lacking in knowledge and experience in relation to keeping a resident comfortable. In this situation the patient is also presented as a critic of the non-specialist nurse practice. Thus credibility for the

patient was not only about presenting oneself as sound of mind but also a critic of non-specialist nurse practice. This identifies the discerning and knowledgeable performance of the patient and this patient is believable because she is 'just right' she is sound in the mind.

We argue that the moral identities that patients are given may have implications for the care that they receive from medical and nursing staff. Thus how knowledge is generated in the daily practice of health care professional through their talk about patients is very important for example in accessing resources such as specialist palliative care in care homes and access to supportive therapy such as counseling. We argue that practitioners should not only reflect on practice but also reflect on the knowledge claims, which underpin that practice. Using the tools of CA to analyse emotion talk, enables us to unpack how practitioners make sense of patient's behavior and how they characterize patients as troubled (difficult) and credible (on the ball). The patient's disease status is part of this characterization but so is their interaction with and demands that they make on staff. We have shown how the dying trajectory, the deteriorating emotional body and the sound mind is of importance in the characterization of how the credible and troubled patient is achieved in staff talk.

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## **Appendix 1**

Curriculum Vitae (CV): it is not used in its everyday meaning, that is, a CV for academic/job interviews. It is used in a specific sense, that is, a negotiated CV which is jointly constructed by participants in talk. Credentials constructed in participants' talk include personal qualities such as having a good sense of humour, showing sympathy and concern, displaying good manners (Li, 2002).

## Appendix 2

Periods between words:	'I am.....ok...': Pauses in seconds of a minute
<u>Underlined words:</u>	Draws readers' attention to particular words or sentences used by participants
Single quotation marks in the data:	'P is frightened': Represents an instance of a Nurse's talk
Numbered lines in the data:	Created by NUDIST software program. Used to identify the position of lines when analysing the data

## Appendix 3

Table 1: Instances of analytic categories of troubled patients occurring

### 'TROUBLED PATIENTS'

Frequency distribution at a rate per 10 hours of observation:

	H1		H 2		HP1	
	Observed Rate per	Observed Rate per	Observed Rate per	Observed Rate per	Observed Rate per	Observed Rate per
	Instances 10 hours	Instances 10 hours	Instances 10 hours	Instances 10 hours	Instances 10 hours	Instances 10 hours
THE 'TROUBLED' PERSON						
Difficult' characters	17	4.86	28	7.00	13	2.06
The 'troubled' mind	23	6.57	15	3.75	15	2.38
The 'troubled' body & mind	27	7.71	30	7.50	22	3.49
Total hours of observation	35 Hours		40 Hours		63 Hours	
Done						
Total episodes of observation	11		11		24	

Key: H1-Hospice 1; H2 – Hospice 2; HP1- General Hospital 1



## Appendix 4

Table 1 word count of adjectives to describe troubled patients

Keys: H1-Hospice 1; H2 – Hospice 2; HP1- General Hospital 1

Key words	H1	H2	HP1	Total
Difficult	17	28	13	58
Anxious	8	16	4	28
Anxiety				
Bad	2	17	6	25
Confused	7	13	5	25
Complaining	11	4	8	23
Poor	8	11	3	22
Fear and/or Frightened	5	6	8	19
Low	6	7	3	16
Angry	7	4	4	15
Upset	3	8	4	15
Agitated	5	7	1	13
Worried	4	7	2	13
Restless	6	5	1	12
Down	0	5	5	10
(Dis)stressed	4	5	0	9
Depressed	3	5	1	9
Aggressive	4	4	0	8

## Appendix 5

Table 2 Expressions associated with troubled and credible patients

<b>Troubled patient</b>	<b>Credible patient</b>
<p>She's dying, agitated, restless,  muddles; she was an anxious lady  he is very angry and it is too late to  help him ease his anger; she is a  very difficult lady and any body  will find her difficult, she's a very  frightened lady</p>	<p>Bright as a button, on the ball  a darling, she's totally with it  she can get about, she is such  a sweet heart, nice little family  he is much brighter and  positive, he was a cheerful  bunny yesterday</p>

## Appendix 6

Table 3 A summary of strategies for the construction of troubled and credible patients

Category	Main Strategies	Sub-strategies	Sub-sub strategies	What's Revealed
Troubled Patient	Protective	In-group identity	I and we	Collegial Relationship Team niceness Emotional Involvement
	Deflective	markers Inclusive markers		
	Blame-shifting	Extreme markers Uncertainty markers Troubled person troubled body	Any one Very Looks like	Reciprocity Mutuality Cautious, nice and credible professionals Sharedness of the situation – troubles and tension
Credible Patient	Contrastive rhetoric Contrasting device	Inclusive Markers Team-like coalition Device	you know	Mutual production Emotional involvement Cautious and nice Professionals Troubles and Tension Personal credibility Patient credibility
		Exclusive markers	they	Sharedness of the situation
		Extreme markers Uncertainty markers	amazing such I think I wondered	
Troubled & Credible Patient	Atrocity stories	Emotional editing  deep and surface acting	extreme case formulation  contrastive deflective and protective devices	Undesirable Emotions blocked  Troubled patient made credible Credible patient more credible