MANAGING CALLS TO MAURI ORA: MEDICAL RECEPTION IN ACTION

BY

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Abstract

Often a patient's first contact with their health service is through a medical receptionist. Literature has framed medical receptionists as gate-keepers, and few studies have examined what they actually do when they answer incoming calls by studying recordings of them. The current thesis asks how receptionists managed calls to Mauri Ora, a student health service, to deliver what the callers were asking for. The findings present evidence that receptionists are skilled and supportive in their interactions with patients.

Following discursive psychology and conversation analysis as theoretical and methodological frameworks this thesis examined naturally occurring social interactions to discover how joint understanding and coordinated action was accomplished. Eighteen (*N=18)* calls between receptionists and patients were recorded, transcribed and examined in detail for what happened in each call and how receptionists worked to deliver what the callers were asking for.

Callers ring with a broad range of different problems. The analysis documents how receptionists showed that they understood what callers wanted, and the ways they worked to progress solutions. The examination of requests for doctors' appointments were of particular interest because of their very limited availability and the triage process for getting one. By establishing with the caller the conditions under which they could see a doctor, including if it was an urgent problem, receptionists opened the door to the health care being sought. A difficult matter for receptionists is asking for and responding to health-related information because they have no medical training. An additional aspect of the analysis demonstrated that receptionists only asked for medical information as a record for triage referral, and when it had not previously been disclosed.

Far from casting medical receptionists as gate-keepers withholding help, the current thesis demonstrates their orientation towards granting the requests of callers and doing what they can to facilitate access to health care. Practical applications for the training and practice of medical receptionists are considered as well as future research, and the ethical constraints of this kind of work.

Contents

Chapter 1: Introduction

Speaking to a receptionist over the phone or at the front desk is often the first contact a patient has with their health care service. As the first step towards a clinical encounter, the conversation with a receptionist is critical. Yet, both within policy and research the work of receptionists is largely overlooked. The New Zealand Ministry of Health's most recent strategic plan makes no reference to receptionists at all (New Zealand Ministry of Health, 2016). Although newly developed models of care, like that of the Health Care Home Collaborative (2018b) acknowledge the importance of receptionists' role the complex dynamics of *how* receptionists do their work deserves further investigation. As the delivery of primary care shifts further towards systems that emphasis the use of telephone-based triaging processes to manage demand, consideration of the role receptionists in general practice have in delivering health care is increasingly important.

Likewise, medical communication has been studied extensively (e.g. Teas Gill & Roberts, 2012) yet only a handful of studies investigate the position and work of medical receptionists. Fewer still ask how they do their jobs (Sikveland & Stokoe, 2017a, 2017b; Sikveland, Stokoe, Demjen, 2019; Sikveland, Stokoe, & Symonds, 2016; Stokoe, Sikveland, & Symonds, 2016). What little research does exist has not always presented receptionists favourably but has suggested that receptionists are impersonal gate-keepers who withhold access to care (Arber & Sawyer, 1985; Hewitt, McCloughan, & McKinstry, 2009). A complicating factor in the work of receptionists that necessarily involves health-related information is that although they are trained on the job they are not necessarily medically trained. That we know little about the work that receptionists do, and that it is often overlooked suggests that it is considered to be unimportant or unskilled. Although taken-for-granted it is reasonable to suggest that the first interaction between patient and receptionist is oftentimes the first impression of the service to be offered. To address this gap in the research in this thesis, I examine how medical receptionists in general practice perform their role *in situ*. Using discursive psychology as the theoretical framework, I examine calls between receptionists and callers to *Mauri Ora Student Health and Counselling* at Victoria University of Wellington. Analysing the calls using conversation analysis, I take an ethnomethodological approach to document the skilled practices that receptionists use in their everyday work.

This chapter provides an overview of literature medical receptionist work that justifies and motivates this research. Following this, I review key literature in the areas of medical communication and telephone mediated service encounters that have informed the research questions and analysis. I will then introduce the theoretical frameworks that I have employed, by discussing discursive psychology and conversation analysis theory.

Review of the literature

The Medical Receptionist. Research on the role of the medical receptionist is limited in comparison to other areas of health and medicine (Teas Gill & Roberts, 2012), and has cast receptionists as gate-keepers who mediate patients' access to health professionals (Arber & Sawyer, 1985; Gallagher, Pearson, Drinkwater, & Guy, 2001; Hewitt et al., 2009; Paddison et al., 2015). Even popular media discourse reproduces this portrayal of the medical receptionist. A series of comedic sketches [parodying the hospital receptionist](#) reflects just this – that they are unhelpful at best and actively block access to care at worst (Little Britain USA, 2008). Studies of patients' perceptions of the medical receptionist reinforce this idea (Arber & Sawyer, 1985; Hewitt et al., 2009; Paddison et al., 2015). For patients in the United Kingdom, the helpfulness of receptionists is second only to communication with their doctor in determining how satisfied they are with their primary care provider (Paddison et al., 2015). Receptionists are described as "officious" (Arber & Sawyer, 1985, p. 918; Hewitt et al., 2009, p. 261) prioritising organisational goals over the needs of patients and making medical decisions outside their legitimate realm of expertise (Paddison et al., 2015). While receptionists report doing their best to help patients, patients have nevertheless described interactions with them as insensitive and impersonal (Hewitt et al., 2009). This literature suggests increased communication training as a remedy to the perception of receptionists as routine-focused and unhelpful (Hewitt et al., 2009; Paddison et al., 2015).

Other studies however, present a different perception of medical receptionists, as caring, compassionate workers, who are constrained in their ability to help patients as much as they would like (Arroll, 2011; Hammond et al., 2013; Neuwelt, Kearns, & Browne, 2015; Neuwelt, Kearns, & Cairns, 2016; Neuwelt et al., 2016; Swinglehurst, Greenhalgh, Russell, & Myall, 2011). Although the level of sensitivity receptionists show to patients is not always recognised (Neuwelt et al., 2016; Swinglehurst et al., 2011). Indeed, the role receptionists occupy is one of "critical influence in transforming 'a person' into 'a patient'" (Neuwelt et al., 2015, p. 289). Despite occupying a critical role where they are able to identify problems

in the way services are delivered, the structures of power in the medical system afford medical receptionists little agency to improve services for patients (Neuwelt et al., 2015) or working conditions for themselves (Neuwelt et al., 2016).

Although studies on the medical receptionist's role are scarce, fewer still investigate the interaction receptionists have with patients (Gallagher et al., 2001; Hewitt et al., 2009; Sikveland & Stokoe, 2017a, 2017b; Sikveland et al., 2019; Sikveland et al., 2016; Stokoe et al., 2016). An observational study of general practice concluded that receptionists tended to *persuade* patients against booking appointment (towards alternative options), in an attempt to temper demand on doctors (Gallagher et al., 2001), furthering the perception that they are gate-keepers. An analysis of audio recorded face-to-face interactions (Hewitt et al., 2009) suggested that receptionists engaged in three styles of communication (*conventionally polite, rapport building, task-centred*) that were similarly efficient, yet *task-centred* communication was interpreted as too direct and dismissive by the researchers and patients alike. Hewitt and colleagues (2009) tied these communication styles to patients' reports of negative experiences with medical receptionists. Thus, research suggests that receptionists communicate in ways that are too focussed on gate-keeping and the task at hand, and that this is detrimental to their relationship with patients.

Studying the interaction between receptionists and patients allows for the identification of where and how problems in communication arise. Another enquiry into the patient-receptionist interaction investigated calls to general practices in the United Kingdom using conversation analysis (Sikveland & Stokoe, 2017a, 2017b, Sikveland et al., 2019; Sikveland et al., 2016; Stokoe et al., 2016). One such disruption identified was callers carrying the 'burden' of driving the call forward to a solution, when their initial requests were not granted by receptionists (Sikveland et al., 2016; Stokoe et al., 2016). At the end of calls, disruption occurred when patients displayed uncertainty about what would happen next; bearing the burden of seeking confirmation so that the call could come to a close. The researchers described receptionists who pre-empted these possible disruptions and drove the call forward (with alternative offers and confirmations) as more effectively handling their calls. These observations were found to statistically correlate with patients reports' of their satisfaction with service (Sikveland et al., 2016; Stokoe et al., 2016).

Triaging and General Practice Reception. As new models of primary care are implemented (Health Care Home Collaborative, 2018b), consideration of telephone-based

triaging at GP receptionist is increasingly a for consideration in the practice of receptionists. Designed to manage demand on clinical services (O'Meara, Porter, & Greaves, 2007), triaging practices involve receptionists in discerning which presenting patients are unwell (Arroll, 2011). Requiring receptionists to manage health information and assess medical problems, triaging is among the clinical work that general practice receptionists do that they are not necessarily properly trained or reimbursed for (Arroll, 2011; Neuwelt et al., 2015, 2016; Patterson, Forrester, Price, & Desley, 2005). In New Zealand, general practice receptionists have been described as invisible clinicians whose contributions to clinical work go largely unnoticed (Arroll, 2014). An interview study of New Zealand general practice receptionists reported that they felt undervalued and undermined by colleagues, particularly when clinicians demonstrated a lack of understanding of what they do (Neuwelt et al., 2016). Receptionists report this kind of clinical work to be a challenging aspect of their job and describe the difficultly of balancing responsibility to patients and their practice (Neuwelt et al., 2016) a concern that is particularly relevant when managing demand for appointments. However, interviews with general practice receptionists in the UK revealed they found asking about what a patient's problem when booking an appointment was a useful way to redirect demand towards more appropriate or available services (Gallagher et al., 2001).

The way receptionists gather information for triage impacts how calls progress. For general practice receptionists in the UK, asking whether a problem was urgent or routine led callers to respond with resistance by saying things like *uh well it's not urgent, but I could do with seeing someone today* (parsed, Sikveland et al., 2019, p.10). A more effective triaging practice was asking callers questions that solicited an account of why they needed urgent care. However, this presented another problem for callers who were reluctant to tell the receptionist what their problem was, reflecting the perception that receptionists are beyond their remit when making medical judgements (Paddison et al., 2015). In the interviews conducted Gallagher reported that even when prohibited by policy to enquire about health-related information, receptionists managed to solicit useful information by asking if a patient's problem was urgent or could wait. Moreover, in examining recorded face-to-face reception work Gallagher reported that receptionists solicited information "by creating silences during phone or face-to-face consultations for the patient to fill with information" (Gallagher et al., 2001, p.282). Although some patients reported feeling that disclosing information to the receptionist showed why they needed an appointment and legitimated their request, others felt it was not appropriate to do. Finally, to mitigate the trouble triaging can

lead to, Sikveland and colleagues (2017a, Sikveland et al., 2019) suggest that receptionists should not ask about urgency unless patients request an urgent appointment.

This review of literature on the medical receptionist's role, and their interactions with patients shows a contradiction in findings about the work receptionists do. Although there is agreement that the work of medical receptionists is complex, demanding and entails a high degree of responsibility to patients and practice (Gallagher et al., 2001; Hammond et al., 2013; Neuwelt et al., 2016), relatively little is known about how it is done. Moreover, literature has acknowledged the contextual factors that contribute to the challenges of doing medical reception work. Importantly, some research also presents an alternative view of receptionists as caring and compassionate members of the health work force (Hammond et al., 2013; Neuwelt et al., 2016). Yet, the problem persists that there is a lack of research showing *how* receptionists actually do their work, in order to identify where troubles occur and whether receptionists help or hinder patients and facilitate access to care. This thesis addresses address this gap in the literature and furthers the empirical inquiry into how medical receptionists do their work.

Medical Communication. There is a substantive body of research on medical communication, and here I review key studies that have relevance for understanding and examining actions that occur in interaction between receptionists and patients. For nearly thirty years, interactional scholars have examined medical encounters. These studies have shed light on how diagnosis, giving advice, examination and history taking are actually accomplished in an interaction (for a detailed discussion see Teas Gill & Roberts, 2012). Inaugural work on medical communication documented the communicative practices of doctors through the stages primary care encounters (Byrne & Long, 1976) and established a relationship between doctors' poor communication and patients' compliance with their recommendations (Korsch & Negrete, 1972). This body of research is extensive, so I focus on key literature that deals with how patients present their problems to health professionals.

The interactional context of medical encounters is important for making sense of what happens within them and how they unfold. The organisation of the medical consultation is well established, showing there are distinct parts that come together to form the whole, which are oriented to by patients and doctors alike (Heritage & Maynard, 2006). This work has

established how medical consultations are organised as an overall unit of interaction, stepping through an orderly series of activities from opening to close. In an analysis of visits where patients present new problems, Robinson (2003) conceptualises this organisation as cohering into an *interactional project.* He contrasts this with *activities,* which are maintained courses of action over one or a series of sequences (Heritage & Sorjonen, 1994). In acute primary care visits, these activities are: *opening, problem presentation, history taking, physical examination, diagnosis, treatment, closing* (Heritage & Maynard, 2006; Robinson, 2003). It is the problem presented by the patient that establishes what the interactional project is, and how the consultation will progress (Robinson, 2003). How participants move through activities is consequential for the accomplishment of the interactional project. The problem presentation phase of the visit allows patients the greatest opportunity to present the reason for visit in terms of their own agendas (Heritage & Robinson, 2006).

What it is to be a patient has itself been an object of enquiry, and the notion of social roles is key to how patients communicate what they are experiencing. Perhaps the most enduring conception of what it is to be unwell is Parsons (1951) "sick role", that affords people particular rights and obligations. On the one hand, being sick entitles one to exemption from normal activities, and the responsibility for one's illness. On the other, being sick obliges one to want to recover, to seek competent help, and comply with the treatment. Seeking medical care too frequently, or without good reason carries the risk of an undesirable evaluation of one's character (Heritage & Clayman, 2010). The shared understanding of this role is demonstrable in how patients talk about their reasons for visiting the doctor (Halkowski, 2006; Heritage & Robinson, 2006). Thus, how patients present their problem is necessarily tied up with the presentation of themselves (Goffman, 1959; Halkowski, 2006; Heritage & Clayman, 2010; Heritage & Robinson, 2006).

In taking on the sick role, patients present their problems to doctors in ways that demonstrate "doctorability" (Heritage & Robinson, 2006, p.58). Patients describe their problem in ways that are consequential for their presentation of themselves as reasonable patients. When parents of children present 'symptoms only' presentations they can be heard as seeking advice, while parents who include a 'candidate diagnosis' can be heard as seeking confirmation and treatment of the illness (Stivers, 2002). Patients make diagnostic claims but treat these a within the doctor's proper remit (Heritage & Robinson, 2006). Where these diagnostic claims are made, patients also display their understanding of the problem as one that is clearly doctorable and/or treatable. So, while patients do describe their illness or

problem in medical terms, they orient to their role as a patient in relation to the role of the doctor as a medical professional, and the knowledge and rights associated with each role (Heritage, 2012). Furthermore, patients design the presentations of their problems in ways that show them to have "appropriate awareness of [their] bodily sensations and symptoms" (Halkowski, 2006, p. 91) and to be seeking care at precisely the right time. In these "narratives of symptom discovery" (p. 93) patient describe happening upon their symptomatic sensations, rather than searching for them.

As Zola (1973) argued, deciding to seek medical care is a fundamentally social process. Patients also invoke the advice of others to seek medical care (Heritage & Robinson, 2006). Doing so serves to legitimate a patient's presence in the doctor's office and mitigate their responsibility for seeking help (Heritage & Robinson, 2006). When presenting in the doctor's office for an appointment, patients have already taken on the sick role, and committed to the legitimate doctorability of their problem (Halkowski, 2006; Heritage & Clayman, 2010). Yet, they still display an orientation towards presenting themselves as reasonably and justifiably seeking care. This is the patient's problem (Halkowski, 2006; Heritage & Clayman, 2010; Heritage & Robinson, 2006); they must balance the presentation of themselves as both reasonable and having a doctorable problem.

Primarily, this research has focused on doctor-patient interactions, which to date has reflected the structure of the medical world which is fundamentally asymmetrical (Pilnick & Dingwall, 2011), and in which receptionists are relatively overlooked. This provides a justification for the examination of patients' communication with other members of the health workforce who are frequently excluded from practical and empirical consideration. I analyse interactions between patients and receptionists over the phone. Below I review relevant research on telephone communication.

Telephone Mediated Service Encounters. There is a substantive body of work on telephone mediated service encounters which is relevant to understanding how communication between receptionists and callers works. These studies cover a broad range of services yet provide an understanding of how medical receptionists manage telephone calls and the practical problems that the work of medical receptionist involves.

Early examination of helpline calls revealed that who one person is to another – their relationship – is fundamental to helping. In early work, Sacks examined calls to suicide

helplines (Sacks, 1966) establishing a clear link between helping and social relationships. Sacks puzzled over why callers paradoxically asserted that they had "no one to turn to" while talking to a counsellor on the phone. Sacks showed that the reasons people gave for asking counsellors for help, were focused on why they had not turned to those with whom they had close relationships. Literature on how people help in emergencies also points to the importance of social relationships, suggesting feeling responsible is implicated in peoples' willingness to help (Latané & Darley, 1970) and that the act of asking for help creates a bond between people that increases motivation to help (Moriarty, 1975). Although cognitive social psychology conceptualises helping as something internally motivated and justified, Sacks demonstrated that the relationship that made helping appropriate was locally produced through interactional practices. Helpline counsellors transformed the problem into one that a caller's close relations could not help with even if turned to, reframing themselves as the right person to ask for help (Sacks, 1966). In their institutional role, the helpline counsellors were afforded the rights and responsibility to help callers but critically, the help itself and the relationship that made them responsible for helping was constructed through talk.

People routinely orient to asking for help from institutions as an *accountable* matter, that is, something that they need to give a reason for doing (Robinson, 2016). Early work in the area of emergency calls looked largely at calls to the police, showing how callers accounted for their knowledge of an incident requiring emergency assistance (Whalen & Zimmerman, 1987, 1990; Zimmerman, 1992). Much like patients in the doctor's office, callers to emergency services show their knowledge of the incident through their description of it (Whalen & Zimmerman, 1990). Entitlement to emergency services is tied up with rights to knowledge of the problem (e.g. near my house, I just witnessed) and whether the problem constitutes an emergency. How the incident is described and accounted for is consequential for constructing caller's entitlement to help.

Asking for help is not only about showing that one has a problem for which they are entitled to seek help, but also that they have sought help only because they cannot resolve the problem themselves. In a study of calls to a mediation service for problem neighbours, callers who have not mentioned any efforts to resolves problems for themselves demonstrate an understanding of the preference for self help in how they account for why they are unable to resolve the problem themselves (Edwards & Stokoe, 2007). These findings demonstrate that how people ask for and give help show their common-sense understandings of the rights and responsibilities that come with seeking help.

Studies of telephone communications also show the ways call takers are constrained by and work within protocols and policies. A good example of how constraints are managed in interaction is where protocols are strict. In calls to emergency services, it is critically important to quickly gather details on the incident, including what has happened and where. Alignment – that is, joint understanding about the action to be accomplished – is critical (Jefferson & Lee, 1981). In a high-stakes situation, misalignment regarding what kind of information call takers are requesting can be fatal (Whalen, Zimmerman, & Whalen, 1988). Trouble can arise when callers disclose their problem before dispatchers gather details of the incident (Riou et al., 2018). Call takers manage this problem with a "pre-emption repeat" (Riou et al., 2018, p. 679) recycling previously disclosed details to solicit a confirmation to manage the constraints they operate within. When asking for a report of the incident *'what's happened'* versus *'what happened'* solicited a report that was shorter in time by half (Riou et al., 2017). This shows how minute, yet skilful interactional practices can be deployed within institutional constraints to achieve better outcomes for callers. With call-takers being institutionally required to fulfil certain contingencies to offer services, misalignment on where, how and why call-taker's ask questions is highly consequential for how an interaction unfolds.

Working within procedural constraints, call-takers draw on interactional resources to make decisions about how best to progress a call, for example whether to ask questions relevant to dispatch immediately, or gather information about the incident (Larsen, 2013). Which way they decide is dependent on the entitlement to help encoded in the caller's request. Requests convey entitlement in their design, with modal verbs (e.g. can you) denoting higher entitlement than 'I wonder if' formulations (Curl & Drew, 2008). Larsen (2013) argues that effective handing of these calls is a demonstration of the dispatcher's knowledge and experience working within the constraints of the dispatch protocol, applied in practice to logically progress the call in the most efficient manner.

Availability of services also matters for how call takers manage interactions with callers. This is especially relevant in the interactions between medical receptionists and callers. Declining to grant requests causes an interactional road block where callers have to push through by asking for what they want (Sikveland et al., 2016; Stokoe et al., 2016). If what callers ask for is not strictly available Stokoe and colleagues (2016) suggest that what is more effective, is for receptionists to clearly convey what they are doing to grant callers' requests and that they are doing something to progress the encounter. Another way to manage

non-grantable requests is to shape them into ones that can be granted– a practice termed *extended requesting* (Lee, 2009, 2011) used by airline booking agents. Lee (2009) argues that call takers unpack and reshape glossed or unspecific requests, applying their specialised knowledge of what is available and on offer. Over a series of questions, the agents specified what callers were asking for and established the parameters for granting, which callers collaborated with by further specifying their request in line with what the agents constructed as grantable. Lee (2011) notes, that the agents skilfully avoid an on-the-record non-granting. Evident in the troubles and practices deployed to overcome them in these studies is that the call takers hold the knowledge and rights necessary to progress the interaction, while callers are more often naïve about process and the availability of services (Lee, 2009; Lee 2011; Sikveland et al., 2016; Stokoe et al., 2016), reflecting how differences in knowledge come to the fore in practice (Heritage, 2012).

The boundaries of the institutional remit call-takers operate within also constrains how they communicate with callers. For example, medical receptionists are not medically trained but must deal with health-related information in their work. Similar problems arise in calls to children's and cancer helplines, where call-takers must deal with complex and sensitive issues that they may not be fully able and competent to manage. Nurses on cancer helplines are restricted in their ability to diagnose or provide patients with new information or prognoses, yet often in seeking advice, support or reassurance this is exactly what callers want (Woods, 2016; Woods, Drew, & Leydon, 2015). A study of calls to an Australian helpline for children's health where nurses are not permitted to provide medical advice examined how nurses negotiated the boundaries of what constituted information and advice (Butler, Danby, Emmison, & Thorpe, 2009). This was accomplished using interactional practices that framed what they were saying as information. When asked for advice, they drew on their identity as a nurse to establish the boundaries of their knowledge (i.e. not a doctor), their expertise in matters to do with children's health that addressed the caller's problem without directly giving advice and centred the parent's rights to make decisions about what to do. At Kids Helpline counsellors are mandated not to give advice and analysis of calls to the helpline demonstrates further how the boundaries of a call taker's role are enacted in practice (Butler, Danby, & Emmison, 2015). In this case however, not giving advice was tied to the counsellor's role in empowering young people to come to their own solutions and so fulfilled the goals of the institution and interaction. Approaching the study of

call between receptionists and callers at Mauri Ora, this work has informed my research questions.

Theoretical and methodological frameworks

The key theoretical and methodological frameworks within which the present thesis is situated are conversation analysis and discursive psychology.

Conversation Analysis. Contributing to the development of discursive psychology and rooted in the ethnomethodological lineage of thought, is the theory and method of conversation analysis (CA). Grounded in Harvey Sacks' (1992) *Lectures on Conversation*, conversation analysis was developed further in association with Emmanuel Schegloff and Gail Jefferson (see Sacks, Schegloff, & Jefferson, 1974). Conversation analysis seeks to describe and explain the competencies and structures that speakers use to accomplish intelligible, organised social action (Atkinson & Heritage, 1984). In all contexts, the fundamental and ubiquitous question conversation analysts ask of talk is *why that now?* In answer, the conversation analytic method reveals what the action of an utterance is relative to the talk which preceded it, and in turn what action that projects onto succeeding talk (Heritage & Clayman, 2010; Schegloff, 2007). This innovative notion of *sequentiality* is what makes conversation analysis distinctive to other methods of examining social interaction. In focusing on the sequential unfolding of talk, conversation analysis takes the position that not only analysts but participants (speakers and hearers or recipients of a social action) themselves analyse and monitor their co-participants talk for action, and that their interpretation of that action shapes their own forthcoming action, and so on. In this way, talk in context shaped and context renewing (Heritage & Maynard, 2006).

Moreover, writing on Sacks' legacy in psychological science, Edwards observed that "any analysis of how conversational interaction works has an immediate relevance for *social* psychology, and might be considered, without further comment *as* social psychology" (Edwards, 1995, p. 580 emphasis in original). Informing Sacks' intellectual work are the works Erving Goffman (1972, 1983) and Harold Garfinkel (1967). Goffman theorised that social interaction is a social institution in its own right, which carries with it a moral and institutional order – a complex set of interactional rights and obligations (Heritage, 2001). Garfinkel argued further that not only social interactions, but all human institutions and actions rest on the fact that members of a culture can make sense of the situations they are in and act accordingly. Members of society use 'ethno-methods' (shared methods of reasoning)

to build a joint understanding of their surroundings and the social world in general. So, action that is meaningful and coordinated is impossible without the commonly shared understanding that underlies it. Therefore, to draw conceptions of how social action is done without also analysing how the social actors use these shared meaning systems is flawed. Garfinkel termed this intellectual project *ethnomethodology*. Heritage and Clayman (2010) note that the program of research that would become conversation analysis drew on Goffman's notion that *talk-in-interaction* is the "primordial site of human sociality" (Schegloff, 1992, p. 1296) and can be studied in its own right. From the work of Garfinkel developed the assumption that ethno-methods are implicated in the production and understanding of talk, and its step-by-step progression (Sacks et al., 1974). Bringing these ideas together into conversation analysis, Sacks and his colleagues established a previously unconceivable way to elucidate the systematicity and orderliness of human social life (Heritage & Clayman, 2010).

A fundamental concern for people participating in a social interaction (*participants)* is how to make the action implemented by talk intelligible and likewise make sense of their interlocutor's action. As vehicles for action, turns at talk make relevant a next action by a conversational partner (Schegloff, 2007). In doing this next action, participants show that and how they have understood the first action (Robinson, 2016). This "sequential architecture of intersubjectivity" (Heritage, 2004, p. 105) relies on participants making their actions intelligible (Robinson, 2016). Where one or another interlocutor encounters trouble with the intelligibility of an action, they may initiate an attempt to modify the other's understanding or interpretation of their action (Robinson, 2016). This is termed *an account.* Heritage argued that although an account may appear inconsequential, the explanation of action is critical to maintaining intersubjectivity and social order (Heritage, 1988). This notion of accountability is grounded in Garfinkel's early work on the responsibility one has for addressing violations in normative conduct (Goffman, 1963)

Institutional talk. Within conversation analytic studies there is a distinction between talk that occurs in mundane ordinary contexts and talk that occurs in institutional contexts. The rules and structures of ordinary conversation such as the system for turn taking (Sacks et al., 1974), repair (Schegloff, Jefferson, & Sacks, 1977) and sequence organisation (Schegloff, 2007) are the bedrock of institutional interactions (Heritage & Clayman, 2010). While the nature of any given institution and its talk may change over time, the fundamentals remain stable. In this way, institutional talk uses similar practices as mundane talk but for different ends. Drew and Heritage (1992) describe three features that characterise institutional talk.

First, the interaction is geared toward goals that are tied to institutional identities. In the calls examined in the thesis some relevant identities are medical receptionist, caller, nurse and doctor. Goals vary according to the caller's specific reason for calling in each interaction, but it is always the case that callers request a service that the receptionist may provide. Second, the interaction imposes constraints on what constitutes an allowable contribution. In the receptionist/caller interaction, for example, the receptionist may not display empathy in response to a display of emotion the way a friend might be expected to do. Third, the context in which the interaction is situated provides frameworks for constraining and making sense of the actions implemented by talk. For example, in receptionist/caller interactions, a receptionist may ask a caller for their home address, but a caller may not ask a receptionist the same question. Whereas, in a conversation between newly acquainted friends making plans, for example, this would be normative and appropriate.

A form of institutional interaction, the context of service encounters sets up the distribution of obligations and responsibilities regarding the activities (Watson, 1986) which are consequential for how the business of interactions like that between receptionists and callers is accomplished. Moreover talk-in-interaction is the medium through which institutions like medicine and medical practices, and roles of the people who represent them, are brought into being (Heritage & Clayman, 2010). The actions that institutional representatives do through their talk, are both a product of the institution and at the same time build the institution. The theory also necessitates that actions and their corresponding responsive actions are normative, and that deviations from the normative unfolding of action are morally accountable.

Critical perspectives on health research. Critical health psychology is interested in issues of "power, economics and macrosocial processes influence and/or structure health, health care, and society at large (Marks, 2002, p. 16). Using conversation analysis to examine issues like power is an approach that has been criticised for decontextualising interactions (Wetherell, 1998). Yet, others have argued that it does not seek to decontextualise interactions, but rather to give priority to the aspects of it that participants themselves treat as relevant (Schegloff, 1997, 1998). Moreover, research has shown that broader issues of power and knowledge are observable in interaction are observable (Heritage, 2012; Stevanovic, 2018; Stevanovic & Peräkylä, 2012, 2014).

Using conversation analysis to examine the interaction that receptionists have with callers provides a framework for the consideration of how the role of general practice receptionists is treated as relevant by participants *in situ.* Thus, questions of how their role is situated with the broader professional and power structures of the institution of medicine (where they are somewhat overlooked compared to other health professionals (Neuwelt, et al. 2015; Neuwelt et al., 2016)) can be grounded in an analysis of how they interact with callers. Even though I am taking this grounded approach, as the following the chapters will show the findings have implications for policy and practice which is one of the contributions the psychological study of health services can offer (Matarazzo, 1980).

Discursive Psychology. Discursive psychology (DP) is a methodological and theoretical approach to psychological research that examines discourse (talk and texts) as the fundamental site of human sociality. Evolved from the pioneering work of Potter and Wetherell (1987), DP profoundly re-conceptualises "psychology as a domain of practice rather than abstract contemplation" (Wiggins & Potter, 2008, p. 73). Discursive psychology provides an approach to studying talk and text – discourse – as objects of study in and of themselves rather than treating talk as a reflection of thought (Wiggins, 2016). Further, it offers a framework for re-specifying psychological concepts like helping as things that are managed in, and consequential for social interaction (Wiggins, 2016).

As the "primary arena for action, understanding and intersubjectivity" (Wiggins & Potter, 2008, p.73) discursive psychology focuses on studying social interactions like that between receptionists and callers that are the focus of this study. Wiggins and Potter (2008) outline that the discursive approach to psychology rests upon three principles about the nature of talk-in-interaction. First, discourse is constructed and constructive. Talk (and text) are constructed from linguistic and non-linguistic resources like words, categories, or interpretive repertoires that are combined precisely to construct a specific version of the world. Second, discourse is action-oriented. Not only is discourse designed to present a version of reality, but that particular construction serves to accomplish social action too. It is through talk that everyday social actions like requesting (Curl & Drew, 2008) and explaining (Heritage, 1988) are accomplished. Moreover, fundamentally psychological concepts like emotion (e.g. Hepburn, 2004; Perakyla & Sorjonen, 2012) and knowledge (e.g. Raymond & Heritage, 2006; Weatherall, 2011) and identity (Tennent, 2019) can be examined for how they are used in talk to accomplish action. Discursive psychology takes the perspective that talk itself brings these psychological concepts into being (Heritage & Clayman, 2010). Finally,

discourse is situated. Talk is inextricably tied to the environment of its production and only understood according to the prior and following talk. It may also be situated within in an institutional context. As such, it is not possible to examine social interaction outside of the environment in which it naturally exists.

Inspired by studies in ethnomethodology and conversation analysis of how ordinary life is done through social interaction, naturalistic data is vital to putting the theory of discursive psychology into research practice and brings unique benefits to research (Wiggins & Potter, 2008). Studying naturalistic data prevents the imposition of the researchers' own assumptions so that the data, rather than preconceived hypotheses, lead findings. Further, the dilemma of how to translate findings across research and real-world contexts is negated, as capturing interactions *in-situ* means that they can be directly applied to the context from which they were gathered. Finally, the object of study remains situated in the environment of its production, allowing the researcher direct access to the detail, richness and contextual factors that are available and relevant to the people in the interaction (Wiggins &, 2008).

In sum, the theoretical underpinnings of discursive psychology and conversation analysis, and the conversation analytic method form an ideal framework for approaching the question of how medical receptionists actually accomplish their work in conversation with callers.

The present thesis

The present thesis examines how receptionists at Mauri Ora manage calls to progress activities that address callers' requests. The central question of this thesis is how receptionists manage to accomplish their work and do so in ways that demonstrate their orientation towards supporting callers.

This thesis contributes to the current literature in several ways. Literature on the role and work of medical receptionists is scant, yet the literature that does exist points to two very different portrayals of the medical receptionist and the work that they do. The findings of the thesis provide empirical evidence to inform debate about how medical receptionists do their work. To the best of my knowledge the present thesis is the only study of telephone-based receptionist-patient interactions in New Zealand, and only the second study globally (alongside the work reviewed earlier (Sikveland & Stokoe, 2017a, 2017b, Sikveland et al., 2019; Sikveland et al., 2016; Stokoe et al., 2016) that examines recorded telephone

interactions. The theory and methodology of discursive psychology and conversation analysis provide the ideal method of examining these calls as a social interaction.

Further developing the research on medical reception as a social interaction I examine it in a New Zealand setting, in the unique context of Mauri Ora, where a new system of primary health care delivery is re-shaping how receptionists work. As Mauri Ora moves into a new model of primary health care delivery (Health Care Home Collaborative, 2018b), where triaging process are more prominent studying conversations between receptionists and callers can shed light on this important stage of a would-be patient's engagement with their primary health care provider. At each stage, how they present themselves is consequential for progressing to the next. So, how patients present their problem to doctors and otherwise account for seeking medical care provides some basis for understanding how callers describe their problem in calls to Mauri Ora, and why that matters. Of course, when patients are in the consultation room with a doctor the legitimacy of their problem is somewhat validated by their presence in the room (Halkowski, 2006). Contrastingly, when a person is calling for an appointment, this is not yet the case and so the stakes are higher. This is especially relevant when the would-be patient is requesting a same-day appointment (of which there are few).

Having situated the thesis within theory and literature, I move to the following chapter which provides a description and discussion of the method undertaken to produce the data, the analysis and the findings. In Chapter 2, I situate the research within the local setting of Mauri Ora and describe how and why Mauri Ora was chosen. I then document the procedures for collection and analysis of data. I also detail the method of conversation analysis and outline the overall structural organisation of calls to Mauri Ora.

Chapter 2: Method and Analytic Approach

In the introduction, I detailed the theoretical frameworks of discursive psychology and ethnomethodology within which this study operates. In this chapter, the first section describes the setting and procedure for the study. I discuss how key ethical considerations shaped the project and dataset, the research relationships, and the storage and management of data. The second section provides an overview of the interactional context of the data and outlines the overall structural organisation of calls to Mauri Ora.

Setting and Procedure

Background to the Setting. The data for the study were call recordings from Mauri Ora Victoria University of Wellington Student Health and Counselling Service. In te reo Māori,[1] the name *Mauri Ora* conveys something akin to the Western concept of wellbeing (mauri – essence, vitality, life force; ora – to be alive, healthy, well, fit). This name captures the bicultural context of New Zealand, and the role the service plays within the lives of students. The service is the primary healthcare and counselling service provider to the student population of Victoria University of Wellington.

Unique aspects of Mauri Ora informed my motivation to collect data from the service. Mauri Ora is a large practice, located across two university campuses (Kelburn and Pipitea) and demand for both routine and acute care is high. The cyclical nature of the university places uneven strain on services, with extremely high demand during teaching trimesters and reduced pressure during breaks. At times, the wait time for a routine or non-urgent doctor's appointment can be up to three weeks. These wait times are reflective of a national health system under increasing pressure to provide more care than it has capacity to manage (New Zealand Ministry of Health, 2016) and have led to frustration and disenfranchisement on behalf of the student population (Phillip & Mathias, 2018; Jess Potter, 2018; Quirke, 2017). My own experience with Mauri Ora was motivation to examine the incoming calls too. I have been in the unique position of working in the role of a receptionist at Mauri Ora (on a casual basis) and being a student who has used the health service. From this perspective I have had

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[1] The language of tangata whenua, Māori who are the indigenous people of New Zealand.

the chance to experience what it is like to receive phone calls and do reception work, while also using the service and having the experiences of other students shared with me.

Further, Mauri Ora is a part of a shift in New Zealand to models of primary health care, which impact the work receptionists do. Beginning the transition towards the Health Care Home model (Health Care Home Collaborative, 2018b) in 2017 Mauri Ora implemented a telephone triage system to manage same-day appointments.

Figure 1. Health Care Home Patient Journey: When I am unwell. From the Health Care Home Collaborative (2018a). Retrieved from https://www.healthcarehome.org.nz/patient-journey *(reproduced with permission)*

As seen in Figure 1, in this model an unwell patient can expect to call their practice, receive help over the phone if suitable, and be scheduled in for a same-day appointment if required. However, what is not clearly outlined is how a patient progresses through each step. Upon calling the practice, what must take place for the caller to speak to their doctor or access an urgent appointment is not thoroughly considered. At Mauri Ora, receptionists are unable to directly book same-day, priority appointments – this is the remit of the triage nurse who determines whether the patient requires an appointment or whether advice will suffice. With this change taking place, studying conversations between receptionists and patients can shed light on this important stage of a patient's progression through the primary care system.

Procedure

Organisational Agreement. I consulted with management at Mauri Ora and received consent to invite staff and service users to participate, and to collect data from Mauri Ora.

Recruiting Participants. I contacted members of the reception staff by email inviting them to participate. In meetings with staff, I answered questions and provided information sheets and consent forms (see Appendix E; Appendix F). Four of six members of staff volunteered as participants. Callers to Mauri Ora were invited to participate upon phoning. In total, 17 callers volunteered as participants.

Collecting Data. Data was collected for intermittently for several hours, at times suitable to Mauri Ora throughout November 2018 to February 2019. Receptionists recorded phone calls as they received them. A system of data collection was designed to fit alongside existing practices. Mauri Ora phones are operated on a call management software that connects the phone and computer at each work station. As part of routine practice, upon calling Mauri Ora, callers are presented with a pre-recorded message that asks them to indicate what they are calling for so that their call may be appropriately directed. During data collection periods, callers who selected to 'make an appointment' or 'speak to a receptionist' were directed to a pre-recorded message about the study (see Appendix B). If a caller selected 'yes' to having their call recorded, participating receptionists' phones would alert them that the incoming call was a 'Research Call'. Then a window would appear on screen with a button to begin recording, and the call would continue as normal. At the end of the call, the receptionist clicked a button in the same pop-up window to stop recording. An audio file was automatically sent to a dedicated email inbox (monitored by me in real-time), from which I downloaded the file. I then deleted the email files.

I then contacted callers whose recordings I had received to discuss the information sheet and consent form (see Appendix G; Appendix H), which I completed on their behalf during the phone call. In total, 37 recordings in which a phone number was provided were recorded. For each call, I attempted to contact the caller up to a maximum of three times. Of the 37 recordings 19 callers were non-contactable, so their calls were excluded from the corpus. One caller who had consented to their call being recorded declined to participate at this point, and I immediately destroyed their data. I emailed participants a copy of the information sheet and their completed consent form.

The Sample. The final corpus consists of 18^2 recorded calls. The corpus of calls consists of a total duration of 25 minutes of recorded data, with an average call time of one minute and 35 seconds.

Ethical approval process

This study operated under the ethical approval granted by the Victoria University of Wellington Human Ethics Committee (application ID #0000026843). Strict guidelines were put in place to protect the identities and wellbeing of participants. The ethical protocols that were implemented to conduct this research meant that there was a high threshold for determining if data was usable, impacting the sample size. Ethical protocols were revised at several points throughout data collection, in response to challenges and problems encountered.

Data Collection. The nature of the study required that callers gave consent to record their call in real-time. Hence, a chief concern for the project was ensuring that data collection processes allowed callers to give fully informed consent. Given that callers could not decide to participate *before* calling, steps were put in place to ensure they could consent upon calling. As the project was situated in a health care context, I took care not to impede access to help, especially in urgent situations. I also considered participants' time, and how best to minimise the burden consent processes had on them and receptionists. The health context meant that calls could contain sensitive health information, and I considered how to safely manage this too. Initially, informed by previous research involving sensitive telephone data (Tennent, 2019) and a commonly accepted method of data collection, it was proposed that the recorded message alone would be used to obtain consent from callers to have their call recorded for research. However, as advised by ethics committee three checks were determined to be necessary to resolve these concerns.

The first step was the pre-recorded message that briefly introduced the study, obtained consent to record the call, and obtained consent for me as the researcher to contact them to discuss participation (see Appendix B). Further, the research message began with a prompt to skip the message if the call was urgent, or at any point in time. The second step required

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[2] There was one repeat caller who consented to the use of two calls as data.

receptionists to confirm callers' understandings that the call had been recorded for the study, and that I would contact them. The third and final step was for me to contact the callers. This entailed a step-by-step discussion of the information sheet and consent form (see Appendix G; Appendix H), addressing questions and concerns raised. Participants were also given agency over their data and could have any piece of data removed from the corpus (without having to provide a reason) within five working days from providing consent to participate. Two calls were removed from the corpus at the request of the receptionist (before I contacted the caller) and one caller withdrew their data before I discussed the information sheet and consent form. Calls that were partially recorded or that did not contain a phone number were excluded immediately and destroyed.

As data collection progressed, I observed that requiring receptionists to confirm callers' understanding of the recorded message did not fit with their usual practices and was disproportionately time consuming. This meant that sometimes it was not completed, or it was not carried out as outlined in the ethical approval. In the initial period of data collection 32 calls were recorded, and only seven of them could be used in the sample. This represented a burdensome use of time for both receptionists and callers. Moreover, as demonstrated in Extract 2.1, callers treated the confirmation as unnecessary. Just prior to the talk shown in this extract the receptionist (REC) has offered the caller (CAL) an appointment which they have accepted.

Extract 2.1: Yeah yeah yep

```
Maya:201118


01    REC:     o:kay ↑great↑ I'll send you an email regarding um
02             [that appointment]
03    CAL:     [     Oh excell]ent
04    REC:     o[kay  ] >um (0.3) just let you know this calls=
05    CAL:      [okay.]
06    REC:     =been recorded are you happy [for that to be rec]orded
07    CAL:                                 [ >yeah yeah< ↑yep]
08    REC:     .hh ah the resea- researcher is (.) Fiona Grattan  from
09             the School of Psychology: .sh
```

This brief extract demonstrates Maya's (pseudonym) orientation to the confirmation step as inapposite. At line 01 the receptionist, moves to bring the call to a close (Schegloff & Sacks, 1973) confirming that they will send the caller an email regarding the appointment, which the caller assesses as "excellent" (line 03). The receptionist then launches the new action of doing the confirmation check. Then, at line 07, the caller begins speaking in

overlap, with ">yeah yeah< yep". This is a clear example of a multiple saying (Stivers, 2004) with which the caller treats the ongoing course of action (confirmation of recording) as one that is unnecessary and should be halted.

The ethics committee granted permission to alter the protocol. For the remainder of data collection only the pre-recorded message and follow up phone call were used to obtain consent from callers. Phoning callers to confirm their consent proved to be a significant challenge to data collection. Although callers were made aware that they would be contacted, many who had consented to have their call recorded were non-contactable. If the callers were non-contactable, their data was destroyed. This meant that 19 out of 37 viable recordings were not included in the sample.

Research relationships

During the ethical approval process, the ethics committee identified the vulnerability of the receptionists as research participants. In particular, the ethics committee expressed concern about Mauri Ora's access to the data and the possibility of evaluations of individual employees' performance. To address this concern, written consent for the organisational representatives and reception staff outlined that data would not be available to Mauri Ora or used to assess performance in any way. I emphasised in all correspondence that the aim of the analysis was to identify patterns across interactions not to assess individuals.

My existing relationship with Mauri Ora as a service was also a concern for gaining ethical approval, particularly how this might impact the ability of staff to freely consent to participate and retain their confidentiality. The ethics committee suggested that the identity of participating receptionists should be confidential from managers and colleagues at Mauri Ora. Of course, the theoretical assumptions requiring the use of naturalistic data and transcription meant that the identity of participating receptionists could not be confidential from me as the researcher which presented a barrier to ethical approval. So, it was negotiated that I would act with integrity as a researcher in keeping data collected and the identity of those who participated confidential.

Engaging Participants in the Research. As part of the commitment to doing research with people rather than on them, I shared early research findings with staff at Mauri Ora. This created an opportunity for the staff members to ask further questions, draw connections to their own experiences and make observations towards providing findings that are useful to the day to day practice of the work.

Data use and management

Data were stored securely on a private research drive (accessible only to myself and my supervisors) on password protected computers at Victoria University of Wellington. For the purposes of transporting data, an encrypted hard drive and a flash drive were used.

Data were de-identified in a two-fold approach. Audio data were digitally edited using Audacity software, so that identifying information (names, student ID numbers, phone numbers) was inaudible. The audio data were transcribed with pseudonyms replacing identifying information. Mauri Ora consented to be identified as the service that data was collected from. Excerpts of transcribed data are presented in the thesis. Further, as there is a small number of participating receptionists, in analyses and presentations of data they are referred to only as 'receptionist'[3] to further protect their identity.

Use of the Corpus. Data were permitted to be shared under strict conditions. Everyone with whom data excerpts were shared was required to sign a confidentiality agreement (see Appendix I). As audio extracts are included for examination, examiners of the thesis are required to complete the confidentially agreement for use of the corpus.

Analytic Process

Transcription. Using standard conversation analytic conventions (Jefferson, 2004), I transcribed call recordings to represent not only the verbatim speech of participants, but also the features of the delivery of talk. I captured details such intonational contours, silences, and cut-offs or disfluent sounds (Hepburn & Bolden, 2017). This level of detail is based in the theoretical assumptions that underlie the conversation analytic method. That is, "no order of detail in interaction can be dismissed *a priori* as disorderly, accidental, or irrelevant" (Heritage, 1984, p. 241). Although transcripts are produced and used in analysis, the original recorded interaction remains the primary source of data that all observations are grounded in. People in interaction treat these minute details as relevant to accomplishing their action in the moment, so analysts cannot omit them without consideration.

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[3] At Mauri Ora, the staff members who do reception work have the title of Coordinators. This title is a fitting representation of the complex range of tasks and responsibilities their role entails. In the thesis, I refer to Coordinators as Receptionists, to better reflect how this study is situated amongst the existing literature. Moreover, the interaction being studied is one where coordinators are working in their capacity as receptionists.

Turn and Sequence. Transcription is the first step of analysis as conversation analytic transcripts represent the organisation of talk at the levels of turn and sequence. The turn-taking system (Sacks et al., 1974) organises talk in a flexible, context-sensitive way. People build turns of talk from a number of resources, including non-lexical objects, words, clauses, phrases and sentences. Usually people talk one at a time as the end of each turn constructional unit provides resources for speaker change to reoccur in an orderly manner. When trouble occurs in the turn-taking system, there are systematic mechanisms by which participants repair those troubles – whether it is a problem with speaking, hearing, or understanding talk (Schegloff et al., 1977).

Social action unfolds turn by turn. How callers and receptionists respond to the turn-of-talk that the other does shows their understanding of what action that turn did. Turns are organised into action *sequences*, wherein the speaker of one turn at talk makes relevant a particular kind of response from the recipient (the person to whom talk is addressed). For example, a question makes relevant an answer, and a greeting makes relevant a reciprocal greeting. The fundamental structure in sequence organisation is the *adjacency pair* (Schegloff, 2007; Schegloff & Sacks, 1973). These fundamental structures of talk-in-interaction are key to how I analysed the data.

Developing the Analysis. The fundamental aim of conversation is to identify what social actions conversational participants are doing with their talk, and how they accomplish them (Sidnell, 2012). The ways that these actions are accomplished are called *practices*. A practice may be any feature of a turn of talk within a sequence that is distinct in character, is used in particular locations, and has unique consequences for the action that the turn accomplishes (Heritage, 2011). To accomplish an action, the practice must be recognisable and understandable as doing that action. As analysts, one way into knowing what action a practice and a turn-at-talk does is by looking at how participants display their understanding of the action through how they respond to it – their *participant's orientations* (Sacks et al., 1974; Sidnell, 2012). This *next-turn proof procedure* is used to build evidence that is grounded in data for how a practice is used and what action it accomplishes (Sidnell, 2012).

During and after transcription, I closely examined each individual call, observing what was happening in the interactions. My motivation for doing the research meant that I approached the data with some interests and questions in mind. First, I was interested in

whether and how medical receptionists' lack of medical training was consequential in the interactions. Second, I was curious about how receptionists managed callers asking for appointments, given that they are a limited resource. Throughout the analysis, I was continuously engaged in the iterative process of listening to and making analytic notes about the data to develop my lines of analytic inquiry.

While typically conversation analysis progresses by developing collections of phenomena of interest, the small sample size did not readily afford the ability to build robust collections. Rather, developing the analysis involved becoming very familiar with each individual call. By examining what was happening in each call and how that was being accomplished, I began to identify patterns. An early observation was that the timing and availability of appointments was something that receptionists and callers oriented to both implicitly and explicitly as a possible trouble, and time was referred to often. I also noticed that out of the 18 calls collected, nine dealt with urgency in some way and eight of those led to a referral to the triage nurse. Including the calls that dealt with urgency, the interactional project of twelve of the calls was to make an appointment or otherwise directly access medical care. I also noticed that when receptionists asked callers about medical information, this could cause trouble for both them and the caller. Callers described their problems in ways that were interesting and varied.

How urgency was dealt with had been a topic of interest to me and was also identified as something Mauri Ora was interested in too. Clearly relevant to callers and receptionists too, where and how urgency came up in calls became a focus of analysis. The topicalisation of urgency often co-occurred with the solicitation or disclosure of medical information, and so I began to examine how and where the medical information arose. In looking at urgency, how receptionists granted appointment requests then became a focus, both in cases where urgency was topicalised and where it was not. Finally, as I charted the overall progression of action in these calls I began to notice how other kinds of requests (not appointments) were progressed, and how callers treated these requests as accountable actions. Through the iterative process of listening, looking at transcripts, and making observations about what was happening these lines of enquiry were refined and shaped into the analyses presented in the thesis.

I developed and refined my analysis of the calls in collaboration with colleagues (in the Discursive Psychology research group) in data sessions. I also presented data to the

Wellington Interaction Data Analysis group to test the analytic lines of inquiry. The data session is a common practice in conversational analysis, wherein analytic observations are available and open to questioning and challenge by colleagues. Thus, with the help of fellow researchers I validated my observations and analyses.

The interactional context: the overall structural organisation of calls to Mauri Ora

As an initial step in developing the analyses, charting the overall structural organisation provided a basis from which to answer more specific questions. An interactional project can be characterised as the overarching goal of an interaction (Robinson, 2003) and is usually determined in calls to Mauri Ora by the request a caller makes. The interactional project is comprised of a series of activities, which are sequences or turns that seem to cohere into a recognisable type of action – like collecting information. This has been extensively examined in the doctor/patient interaction, showing that where and how a turn happens in relation to the local activity is consequential for how participants make sense of the action implemented by that turn-at-talk. Mapping out the overall project that both participants are oriented to progressing provides the interactional context for the analyses that follow.

The overall structural organisation of calls to Mauri Ora is illustrated in *figure 2*. All calls in the corpus begin with a set of sequences that cohere into an opening activity. Then the interaction moves into the reason for the call, which is typically a request. At this point the calls diverge onto two different trajectories that go hand in hand with a different structural organisation. These different trajectories of action are shaped by the request, and how it can be granted by the receptionist. Analysing these requests was a starting point for examining how the receptionist and caller co-constructed a shared sense of the task (or tasks) to be accomplished in the interaction, and the role that each of them play in accomplishing it.
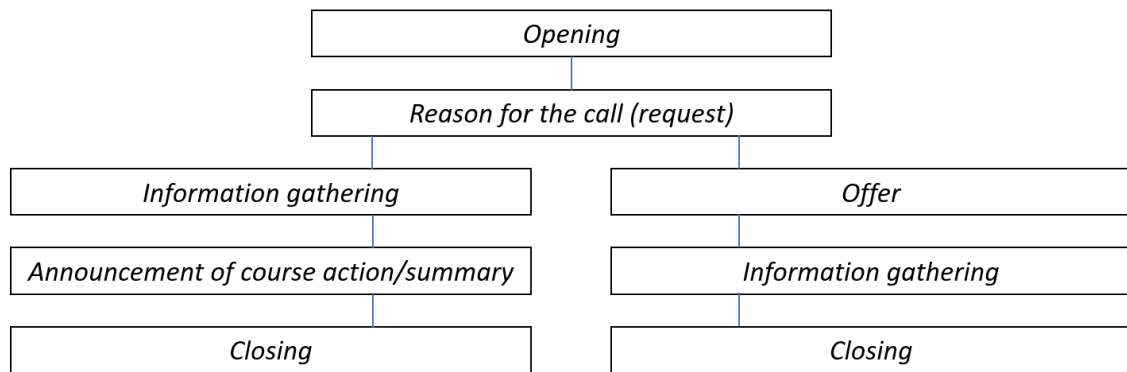
Figure 2: Model of the overall structural organisation of calls to Mauri Ora

Figure 2 shows the two trajectories of action I found, organised by the activities that comprised the whole interaction. The following extract shows what kinds of actions each activity is comprised of, and how they come together into an interactional project.

Extract 2.2 The interactional project

```
Michelle: 101218
```

note: *routine greeting "[Kia ora] Student Health and Counselling you're speaking with [name]/[name] speaking" cut off on recording*

```
01 REC:      -ng with ((NAME))                              answering the call
02           (0.7)
03 CAL:      .hh <hi ((NAME))> um I'd just like to book      opening + reason
04           an appointment                                  for call (request)
05           with one of the doctors in regard to my (.) pi:ll
06           i:'m experiencing a few problems (.) with it so:
07           i'd like to >just< have a chat with one of the
08           doctors °please°,
09 REC:      (0.2)
10           ↑yeah↑ defi↑nitely: what was yo:ur student id?   information
11 CAL:      (0.6)                                            gathering
12 REC:      Um: two thousand h
13 CAL:      [mhm ]
14 REC:      [five] five five nine nine six. .snih
15           ((typing))
16 REC:      (2.2) ((background noises))
17           right Michelle?
18 CAL:      (0.5)
19           .t yep
20 REC:      ((background noises/0.5))
21           okay cool and was your contact number still seven one
```

```
22              zero four one seven five five seven seven?
23 CAL:         (0.5)
24 REC:         yep that's correct hh=
25              =okay so just keep your phone nearby, i've popped      announcement of
26              you on the telephone triage ↑list↑ and someone will    course of action/
27              be in touch to um talk through that with you.          summary
28 CAL:         (0.5)
29 REC:         okay sweet [>thank you very much<]
30 CAL:                    [alright            ]
31 REC:         that's ↑okay↑=
32 CAL:          [bye]                                                 closing
33 REC:         =[tha]nk you ↑bye↑ ((typing))
34                        ((end of recording))
```

At line 01, the receptionist answers the call, and this constitutes one activity. The next activity begins at line 03, where the caller provides their reason for calling, which functions as a request (Larsen, 2013) and as the first part of an adjacency pair that makes granting the request the next relevant action (Schegloff, 2007). The receptionist indicates that she will grant the request, "↑yeah↑ defi↑nitely" (Lindström, 1999) at line 10. Then, they initiate the transition to the next activity, information gathering, that continues until line 24. At line 24, the receptionist announces the course of action they have progressed in a summary. Confirming that the caller has been put on the triage list the receptionists completes the granting and thus accomplishes the interactional project. Within the same turn, at line xx the receptionist transitions to closing the call. There is a sequence of reciprocal appreciation tokens at line 28 and 28, followed by reciprocal farewells (lines 30 and 31). This brief outline demonstrates key concepts of overall structural organisation, activity, interactional project, sequence and adjacency-pair that I use in the analyses.

Summary

In this chapter, I have provided an overview of the setting and motivation for selecting Mauri Ora. I detailed the procedure I used to collect data and ethical considerations that shaped the process. In the second section of the chapter I discussed the analytic process and introduced the interaction context of calls to Mauri Ora. Having done so, I now turn to the analytic chapters.

Chapter 3: Making and understanding requests

This chapter focuses on the practical matter of establishing a joint understanding about what the caller's problem is, and how it can be solved. The analysis I present is the first evidence that receptionists are oriented towards granting requests rather than withholding services on offer. In this chapter, I present data extracts to support my claim that callers make observable their understanding that what they are asking for is an accountable matter. I also show how receptionists use interactional practices to claim and demonstrate understanding of a range of requests and show that they are progressing a solution for the caller. Callers present their reason for calling in both explicit requests and narrative forms. The following analysis presents five extracts that demonstrate some of the ways callers formulated their requests and oriented to what they were asking for as an accountable matter.

When asking for a service from institutions, callers often treat their request as an accountable matter (Halkowski, 2006; Heritage & Robinson, 2006; Whalen & Zimmerman, 1990). In the following extracts, callers accounted for their actions by justifying, explaining, clarifying and repairing their talk. In doing so, callers oriented to their entitlement to make requests (Curl & Drew, 2008; Sacks, 1972), delicacy (Lerner, 2012) and normative preferences for self-help (Edwards & Stokoe, 2007). The analysis reveals the ways receptionists show their understanding of the request and what they can do to progress a solution for the caller. Receptionists display their understanding of callers' interactional project in all cases by moving to grant it. Receptionists also demonstrate their understanding, in formulating the action that they are doing to grant the request, or retrospectively transforming the request into one that is grantable. In doing so, they show their competencies in understanding and responding to requests for a variety of actions that are done in more or less clear ways.

Justifying, explaining and repairing

One way that understanding of an interactional project can be made observable is when callers orient to it by accounting for their behaviour (Heritage, 1988; Robinson, 2016; Whalen & Zimmerman, 1990). In extract 3.1 below, caller Arianna (pseudonym) is requesting to change the time of a previously booked appointment. This case shows a caller treating their behaviour as an accountable matter. Here the interactional project is to

reschedule an appointment and the caller justifies this request with an account for why they need to change the appointment. The receptionist shows their understanding by moving to grant in the next turn and demonstrating how they can provide a solution to the caller's request.

Extract 3.1 Work between two and four

```
Arianna: 221118

01    CAL:   .hh ↑oh↑ hi there ((NAME)) my name's Arianna: >and I was just
02           needing to< change a nurse appointment that I've got
03           booked for next wee:k ↑if possible?
04           (0.3)
05    REC:   .tch su::re
06    CAL:   .hhh  [((inaudible))  ]
07    REC:         [what day and ca]mpus was it booked at,
08    CAL:   a- AH it was booked for three fifteen Wednesday up at
09           Kelburn, .tch a:nd I was just wondering if I could get
10           it (.) slightly earlier in the day (.) or alternatively
11           on (.) Thu:rsday? or Tuesday afternoon?
12           (0.7)
13    REC:   .hh .t u::m °okay I'll just ↑see if I can do it with one
14           another nurse earlie[r in the d]ay, just a moment°
15    CAL:                       [mhm       ]
16           (2.0)
17    REC:   .hh (click) [Arianna Rose isn't it.     ]
18    CAL:               [>it's just i've< gotta wor-] ye:ah i've
19           gotta work be[tween]= two and four
20    REC:                [°mm,°]
```

At lines 01-03, the caller makes an explicit request to change the time of their nurse's appointment. Minimising the request by prefacing it with "just" (line 01) and post-facing it with "↑if possible?" (line 04), treats the request for as something that may place an imposition on the receptionist to grant. In the next turn, the receptionist makes a move towards granting "su::re" (line 05), straightforwardly claiming their understanding of what the caller is asking for and that they are going to grant it (Lindström, 1999). The receptionist then requests information on when and where the appointment was booked for. This request for information shows the receptionist progressing towards a solution for the caller as the information can be used to locate the appointment to be changed. Demonstrating their understanding of this, the caller provides the requested information (line 08-09). Then, they reformulate their request in terms of when they would like to reschedule the appointment. Formulating this request as a "wondering", the caller orients again to the imposition of their

request, and to the receptionist's entitlement to provide a solution (Curl & Drew, 2008). In reformulating the request, the caller further specifies what they have asked for.

With the additional information, in one turn (lines 13-14) the receptionist concurrently demonstrates explicitly their understanding of the request as being for a change in appointment time and formulates what they are going to do to progress a solution for the caller, parsed as *I'll just see if I can do it with another nurse earlier in the day*. The caller however, further displays her orientation to this interactional project as accountable at lines 18-19 "I've gotta work between two and four". This shows the caller's understanding that requesting to change a previously agreed upon appointment time is something that requires a reason. That the caller provides this reason where it is not conditionally relevant, in a location where the receptionist is already progressing the granting shows their orientation to it as relevant to the request. The reason given – work commitments – justifies and accounts for requesting to change an appointment time.

This case demonstrates the receptionist's competent management of a request that the caller treats as accountable. Turn by turn, receptionist and caller show their understanding of the other's action as progressing towards a solution. In demonstrating their understanding and progressing of the caller's interactional project, the receptionist treats this request as one that they can smoothly progress to granting.

Another way that callers orient to the accountability of changing appointments is by explaining what they have done to solve their problem themselves. In extract 3.2, Margaret's reason for calling is to check whether her appointment has been cancelled. This case shows how joint understanding of an implicit request is accomplished and demonstrated by the receptionist.

Extract 3.2 I'm not sure if it went through or not

```
Margaret: 221118

01    CAL:  hi: this is Margaret (.) um: a- i ↑called earlier to::
02          just (0.4) cancel:: (0.2) an appointment that i have at
03          three fif↑teen? >but i'm< not sure if it went-
04          (1.1)
05    REC:  (.tch) oh i c[an check that ] for you:=
06    CAL:               [through or not]
07    REC:  =jus[t give me your id numbe]r thanks (.) ↑.hh
08    CAL:      [((hih hi hh)) thank you]
```

An implicit request, the caller's first turn is done in a narrative format and so does not overtly ask the receptionist to check. Declarative reasons for calling can function as requests (Drew & Couper-Kuhlen, 2014; Whalen & Zimmerman, 1987). The caller first recounts what they have done to cancel the appointment: "um: a- I ↑called earlier to:: <just (0.4) cancel:: (0.2) an appointment I have at the fif↑teen?" (lines 01-03). The caller displays some trouble in formulating their talk – a cut-off "a-" – a hitch in the delivery of the talk (line 07). Restarting, the caller then displays further trouble elongating "to::", which, alongside the minimising "just" and a pause of 0.4 seconds precisely before uttering "cancel::", serve to mark the implementation of the action of *cancelling* as delicate (Lerner, 2012). The action of this turn is to show that the caller has abided by the normative preference for self-help (Edwards & Stokoe, 2007). The caller demonstrates that they have attempted to solve the problem themselves. In prioritising the telling of the attempt at self-help, the caller orients to the preference for self-help and displays their understanding that without this explanation they may be called to account.

The turn reaches possible completions at "fif↑teen?" (line 03), the sped-up talk claims the turn space to produce the upshot of the narrative – that they do not know if they have been successful in cancelling their appointment. This final unit of talk ">but i'm< not sure if it went-" (line 03) is grammatically incomplete, yet projectable in terms of action. The talk is suspended at precisely the point of formulating *why* the caller is calling, displaying an orientation to the delicacy of asking the receptionist to check the appointment. Leaving the turn incomplete, furnishes the receptionist with an opportunity to complete it (Lerner, 2013). So, the caller designs their turn for the receptionist to complete it.

The receptionist progresses the interactional project with an offer (line 05) to check whether the appointment has been cancelled. After a silence of 1.1 seconds (line 04), the receptionist displays their understanding of the action the caller is doing, in the formulation of their offer "oh I can check that for you:". The receptionist marks this turn with an 'oh' preface, claiming understanding (Heritage, 1985). Then, formulating what they have understood is being requested, the receptionist offers to check. The receptionist explicitly formulates the action that was implicit in the callers request thus demonstrating their understanding and also showing the caller how they are going to progress the interactional project. In this way, the receptionist shows the caller they have understood the request and

are progressing a solution to the request. I suggest these interactional practices are evidence of receptionists' skill in managing requests that are done implicitly.

 Another way that callers can orient to the accountability of their request is to repair it, in a way that provides more information about why they are making the request. In extract 3.3, the reason the caller gives for phoning Mauri Ora is to confirm whether they are open. The caller treats their initial formulation as troublesome and repairs it.

Extract 3.3 Asking about opening hours

```
Hayden 1: 201118

01    CAL:   hi its ah hayden gonzales here um i:'m
02           calling in becaus:e. (0.5) well ↓for two things a:h I sent
03           through a prescription earlier today <I just wanted to make
04           sure that student health were still (0.5) a:h open
05           (0.6)
06    CAL:   a:h (0.9) ah (0.2) <ah (0.3) <ah (em/ef) sorry let
07           me be >more specific< <(its/if) the holiday (.) period
08           (hadn't/had) started yet for student health yet
09           >or not.<
10    REC:   tch.hh (.) a:h (.) we we don'- we only close
11           um:: (0.3) Christmas to new year (.) so a two week
12           [period between Christmas and new year]=
13    CAL:   [ Oh  so  you  are  open  during  the ]
14    REC:   =so we are open yes we are .snh[h
15    CAL:                                  [Okay cool.
```

At line 03 the caller begins their request, explicitly formulating a preface to the reason for calling, "i'm calling in becaus:e" (line 01-02). Amidst their turn, at line 02, the caller displays some trouble in formulating what this reason is, pausing their talk for 0.5 seconds precisely at the point where the reason is projectably about to be uttered. Restarting with an insertion repair (Schegloff et al., 1977) that is well-prefaced the caller marks the non-straightforwardness of their reason for calling (Heritage, 2015, 2018) setting the agenda in advance for taking a longer-than-usual turn and making two requests. When the reason for the call is formulated, it is done so explicitly. This first reason for calling is to confirm the opening hours, an action which is tied to making a prescription request earlier in the day (lines 03-05). The reason for calling is explicitly designed as a request for confirmation.

 A gap of 0.6 seconds follows the caller's talk (line 06), where the receptionist could select to speak but does not. In orientation to this lack of uptake as a trouble in understanding, the caller reformulates their request (Schegloff et al., 1977). The caller explicitly frames their talk as a self-repair that targets trouble in the level of detail in the initial formulation "sorry

let me be >more specific<" (lines 07-09). In being "more specific", the caller provides the reason *why* they have asked about the opening hours. The "holiday (.) period" is given as a reason why one might expect the normal opening hours to change and so justifies asking about them, making visible the caller's orientation to what they have requested as an accountable action. Thus, they treat their action as accountable and themselves as not having provided sufficient detail for the request to be intelligible in the initial formulation.

The receptionist progresses this request by providing information about the opening hours. Preliminary to the confirmation they explain the period that Mauri Ora is closed for two weeks from "Christmas to new year". In overlap at line 13, the caller comes in with a claim to understanding "oh" (Heritage, 1985) followed demonstration of their understanding that this means "you are open". Recycling the caller's formulation of their understanding, the receptionist confirms that Mauri Ora is open "so we are open yes we are" (line 14). The receptionist not only confirms the opening hours but provides information correcting the inferentially available understanding about Mauri Ora's holiday hours that the caller has demonstrated in their reason for making the inquiry. This case presents evidence for receptionists' competencies in managing requests.

Explaining the reason for calling

Callers can also make visible their interactional project as an accountable action in the detail given when making their request. Following are two cases in which callers formulate their reason for calling as one that requires a lot of information. I present evidence to show receptionist' competencies in managing these requests through the ways that they progress the granting of them.

In the following case, the caller is requesting a copy of their medical notes. The caller's orientation to their request as an accountable action is observable in their explanation of why they are making the request and are entitled to do so. The receptionist demonstrates their understanding and progresses the caller's project with a transformative answer (T. Stivers & Hayashi, 2010).

Extract 3.4 Requesting a copy of notes from student health

```
Ruby: 211118

  01   CAL:    #hi there# ((clears throat)) um >i need'a make a<  reque:st?
  02           [        (0.3)           ]=
  03           [((bang in background))]
  04   CAL:    =.hh (.) <u:m: i::'ve: <got a lot of chronic health issues,>
  05           including mental, >mental and physical health issues< an' um
  06           .hh i'm moving back to auckland °from wellington 'cause i'm
  07           finishing my degree,° .hh >anyway< my:: .hh family doctor in
  08           auckland has requested that <i::: get a physical copy of all
  09           of my notes, (0.3) from student health?
  10           (0.8)
  11   REC:    .tchh (.) o::ka:y well wha:t we can do: we can pre- we'll
  12           send you a form that you need to complete¿ (.) .hh[h
  13                                                              [y]ip
  14   CAL:    u::m:: an e- you'll- if you can send that form back with:
  15   REC:    (0.2) some form of photo ID: .hh=
  16   CAL:    yip
  17   REC:    =u:m:: (.) then we can arrange for that to be do:ne. so if
  18           y[ou g]ive me your ID: number?
```

From the beginning of the caller's talk, they construct their request as one that requires more than one reason. Starting their turn with a pre-request (Schegloff, 2007) at line 01, the caller prefaces that the forthcoming request is not going to be straightforward. At line 04, the caller characterises their health issues being "chronic", and within the categories of both mental and physical health. The experience of *chronic mental and physical health issues* attends to the accountability of the request to come, in terms of what sort of category membership entitles a person to ask for their medical notes (Sacks, 1972). The caller invokes their identity as a person who experiences chronic health issues as grounds upon which they are entitled to make the forthcoming request (Tennent, 2019). In this preliminary position, this categorisation provides background information in light of which that forthcoming request should be understood.

The caller then accounts further, in this instance providing the precipitating reason for the request, which is that they are moving from Wellington to Auckland because their study at university is ending (lines 06-07). Using a right parenthetical marker ">anyway<" (Sacks, 1992) the caller brackets off the preliminary information and shifts to the request itself. The explicit request for a copy of the caller's medical notes held by student health comes at lines 12-14. The caller invokes the category entitlement of the family doctor (Sacks, 1972) in formulating this request. This acts to justify what the caller is treating as an out-of-the-

ordinary request, with the authority of a medical professional. The caller then constructs her request so as to 'borrow' the entitlement – that she orients to as typically reserved for people who belong to the social category of *doctor* – to access medical information. In light of the request being done, further sense can be made of how the preliminary information serves to justify it.

The receptionist's response comes at line 16 and is a transformative answer (Stivers & Hayashi, 2010).They mark the response to the request as one that is not straightforward. Rather than granting the request *per se,* they transform their response into an offer of what "we" (the institution) can do in order to provide the caller with their medical history. This indicates a problem with the presupposition in the request that the receptionist will be able to grant it. Transforming the request like this, the receptionist retroactivity adjusts the presupposition that they can grant the request to convey that is not straightforwardly the case, but that it is within the institutional domain more broadly. In responding like this, the receptionist's talk shows another way to progress callers' interactional projects – retroactively transforming request in the granting. This shows the receptionist's competencies in managing requests that are designed in such a way that they cannot be straightforwardly granted.

In this case, the caller's orientation to their request as an accountable action is observable in how they explain why they are making the request, and what they have done to solve the problem themselves. Re-joining the call presented in extract 3.3, the following case shows the caller making their second request. Here, the caller is requesting information about their doctor and Mauri Ora to complete a form. The receptionist demonstrates their understanding with a move to grant that explicitly formulates how they are progressing a solution.

Extract 3.5 Requesting doctor's information for medical alert bracelet

```
Hayden 1: 201118

01   CAL:     .h um the other thi:ng is i'm filling out a: (.) <form (0.2)
02            for ah:: medic alert bracelet> for my type one diabetes
03            (0.2) °.h° (.) a:: (.) and it is a:sking fo::r¿:
04            ((background sound/typing))
05   CAL:     <my> doctor and it'(s:/0.3) the practice name and their
06            NZMC number⁴(0.3/°.snh°) um
07            (1.0)
08   CAL:     >i'm i'm< trying (<to) figure out if i need to put through
09            (.)'cause i >i only< (.) the only doctors i see is through
10            student health (0.2) if w- (0.2) what i need to put
11            down in regards to that or if:: i need t[o put down:]:
12   REC:                                             [ ° o:kay ° ]
13            (0.6)
14   REC:     .snh
16   CAL:     ah: doctor gabriel [davis ]
17   REC:                        [do you]=
18            =have a regular doctor that you see at ↑student health?
.
.            ((12 lines omitted: caller disengages briefly and
.             talk restarts, confirming caller does not know Dr))
.
30   REC:     JUst [give me your i]d (.) number here and=
31   CAL:          [ r e c o r d ]
32   REC:     =I'll just see<if I can see who you see regularly .nghh
33            (0.3)
34   CAL:     sure ↑its (.) four seven seven
```

At line 19, the caller introduces the second reason for calling. Like extract 3.2 the request does not directly *ask* for help but is recognisable as a request (Drew & Couper-Kuhlen, 2014; Whalen & Zimmerman, 1987). This second reason for the call, another request for information (line 01-11), is delivered over multiple turns and furnished with a great deal of detail.

The caller first makes visible their orientation to the accountability of their request in explaining why they need the information. Similar to extract 3.4, they draw on their identity as person who has a chronic health condition as the reason for filling out the form. The "medic alert bracelet" is explicitly tied to the caller's health condition "for my type one diabetes" (line 02) (Tennent, 2019). In doing so, the caller orients to asking for information about Mauri Ora's and its doctors as an action that requires a reason.

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⁴ An NZMC number is a registration number for the New Zealand Medical Council. A unique number is allocated to all doctors registered to practice medicine in New Zealand.

The caller then makes their understanding of the request as accountable observable in a second way. After no uptake of the prior turn by the receptionist, at line 08 the caller self-selects to begin a new turn with ">i'm i'm< trying to figure out…". The caller explains further, treating the request so far as unclear. 'Figuring out' here, demonstrates the caller's attempts to complete the required details on the form themselves. Orienting to the preference for self-help (Edwards & Stokoe, 2007) the caller shows that they have not sought help without first trying to solve the problem themselves. Despite their attempts to solve the problem, the caller demonstrates their uncertainty about which doctor to name on the form. Framing the request as seeking advice, the caller proposes one doctor they have considered "doctor Gabriel Davis" (line 16), for confirmation from the receptionist.

The receptionist does not confirm requests for confirmation (line 18) asking the caller instead if they have a "regular doctor" at student health, concurrently demonstrating their understanding of what information the caller needs and formulating the solution. In doing so, the receptionist attempts to grant the request quickly in the next turn. However, the caller does not know who their doctor is (not shown). Nonetheless, continuing to progress a solution at line 30 the receptionist requests the caller's student ID number to access the caller's records. The receptionist explicitly formulates what she is doing to progress the caller's request "I'll just<see if I can see who you see regularly". This shows the receptionist's skilful management of a request that the caller displayed trouble with formulating clearly and treated as accountable. By explicitly formulating the solution into simple yet institutional terms, the receptionist treats the caller's interactional project as something that they can progress without trouble.

Summary

The analysis described the different ways callers made visible their orientations to the accountability of their requests. Callers accounted for their actions by giving reasons for making the request. Callers provided information that explained, justified or clarified the request or repaired talk that they oriented to as unclear. In some cases, callers drew on category entitlement and identity to account for making requests. The reasons were oriented towards having a justifiable reason for making the request (4.1 and 4.2), entitlement to make the request (4.4 and 4.5) and having attempted to solve the problem themselves (4.3 and 4.5). The analysis showed how receptionists' responses displayed understanding of what callers wanted and demonstrated what they were doing to grant the request. Receptionists displayed

understanding in how they moved to grant requests and made explicit claims to understanding. They demonstrated understanding in explicitly formulating what they were doing to progress the request, or an explanation of what could be done to grant the request thus retrospectively transforming what was asked for. Even where requests are not-straightforward receptionists do what they can do grant them.

This chapter has focused on how callers and receptionists established joint understanding of what callers were requesting, and the ways that receptionists progressed callers' requests. The next chapter furthers this argument, with a focus on how receptionists manage appointment requests.

Chapter 4: Receptionists' orientations to the grantability of appointment requests.

A practical problem faced by receptionists and callers is that the wait-time for a routine doctor's appointment is typically around one to two weeks – a period of time that is jointly understood as too long. This presents a dilemma for providing help and accomplishing the relevant action of booking an appointment. In this chapter I show receptionists orient to a preference for granting requests in the turn after they have been made. Where next-turn granting is constrained by the form of the request – as it relates to the institutional limitations on the availability of appointments – receptionists display an orientation to shaping the request into one that can be granted.

As discussed in Chapter 1 telephone mediated service encounters show some ways call takers manage requests that they cannot straight forwardly grant, and orient to contingencies that need to be fulfilled before help can be given (e.g. Whalen & Zimmerman, 1987; Whalen & Zimmerman, 1990, Tennent, 2019). Call takers manage these practical problems by using information available in callers' first turns to make quick decisions on how best to progress calls (Larsen, 2012), or shaping requests by constructing the available options for granting it rather than declining to grant the request (Lee, 2009, 2011).

If receptionists cannot grant request and pose no alternatives, callers may face a 'burden' to secure care (Sikveland et al., 2016; Stokoe et al., 2016). In these calls, establishing the routineness or urgency of an appointment was not an effective method of triaging as callers who did not directly ask for an urgent appointment accepted the offer of one in a few days' time. However, given that at Mauri Ora, the wait time (typically, and certainly at the time of data collection) was over one week I examine how this plays out in calls to Mauri Ora.

In this chapter I examine how requests for doctor's appointments are made and responded to through the presentation and analysis of six extracts. The first three extracts are from calls where the request is made in a way that it can be granted. These demonstrate two courses of actions that can follow a request for an appointment – a booking an appointment or a referring to the triage nurse for a priority appointment or advice. In these cases, receptionists orient to a preference for granting in the next turn. The second three are calls

where the request is made in a way that it cannot be straightforwardly granted. In these cases, receptionists use urgency as a resource to progress the action and provide a solution to the caller's interactional project. The extracts are further evidence, that rather than withholding access to care, the receptionists are oriented towards using available resources to grant requests and facilitate access to health care, and in the most time-efficient manner for the caller.

Requests grantable in the here and now

A practical problem for receptionists when managing requests for appointments is establishing an agreed upon timeframe. The following cases are drawn from three calls in which a grantable request for an appointment is made. The analyses show how the receptionists manage the requests. The cases demonstrate that 1) receptionists are oriented to granting the request, and 2) where it is not immediately grantable, receptionists transform the request into a grantable one.

The first extract (4.1) is presented below. It shows that being able to see someone other than a doctor (i.e. a nurse) is one way that a request can be managed. The receptionist responds to the caller's request with a request for confirmation, that also establishes how the request can be granted.

Extract 4.1 Sexual health appointment

```
Callum: 211118

01    CAL:    hi there um I was wondering if I would be able to book
02            in for a s:tudent (.) <I mean sorry a sexual hea:lth
03            appointment
04            (0.3)
05    CAL:    over the next couple of days or (.) week
06    REC:    Sure °you° happy to see a nurse for that:?
07            (0.2)
08    CAL:    Uh huh,
09            (0.4)
10    REC:    .hh which campus would you like to be seen on.
11            (0.5)
12    CAL:    uhm Kelburn hh .sh
```

The caller specifies in their request what type of appointment they are asking for, and when. Making an explicit request for a sexual health appointment (lines 01-03), the caller's talk reaches turn completion at line 03. The silence that follows (line 04) is a place where the receptionist could respond but does not. In an orientation to a possibly incipient rejection, the caller reconfigures the silence as a pause in their next unit of talk (line 05), an increment.

This utterance is grammatically fitted to the caller's prior talk and retrospectively deletes the space available for the receptionist to come in (Schegloff, 2016), reconstructing his turn as incomplete. With the incremental talk, the caller specifies the timeframe he is seeking the appointment for "over the next couple of days or (.) week" (line 05). Thus, he displays an orientation to the appointment timeframe as the detail that was missing in the prior talk to build a grantable request.

The receptionist's response constructs the conditions under which the caller's interactional project can be progressed. The receptionist's next turn begins with "sure" (line 06), signalling that the request is something that the receptionist is willing and able to grant (Lindström, 1999). The immediately subsequent unit of talk "°you° happy to see a nurse for that:?" (line 06) expands the sequence in a way that shapes the interactional project turn by turn (Lee, 2009, 2011). Although designed as a request for confirmation, the turn also constructs how the request can be granted. The yes/no form "°you happy°" presupposes that the caller will be happy to see a nurse by structurally preferring a 'yes' answer (Raymond, 2003). The turn is designed grammatically and sequentially in a way that makes it easier for the caller to confirm and agree to see a nurse, than to disconfirm. The caller responds after a delay (line 07) with "Uh huh," (line 08) which the receptionist treats as satisfactory and progresses to specifying where the appointment should be located.

In asking this question, the receptionist treats progressing the action as contingent upon the caller's response (Larsen, 2013; Whalen & Zimmerman, 1987; Whalen & Zimmerman, 1990). That is, booking the appointment cannot be progressed until the conditions of its booking are established and agreed to. Demonstrating their experience and competencies, the receptionist neatly packages two actions into one turn, in a way that progresses the caller's interactional project most efficiently. By doing so, they manage the practical wait-time problem by progressing the booking with a nurse.

The next extract (4.3) shows that callers can display their knowledge as experienced service users in their requests. The analysis shows that this is consequential for how the receptionist progresses the caller's interactional project. Here, the receptionist responds to the caller's request with a move to grant in the next turn. However, the practical matter of when the appointment will be then comes to the fore.

Extract 4.2 Doctor asked if I can make an appointment

```
Maya: 201118

01   CAL:     Hello: my names Maya? u:m Kay Tims has got back to me
02            and >asked if< I can make an appointment<to come and
03            see her. hh
05   REC:     °o:kay su:re°=I'm just gonna bring her template up ↑here↑
06            I won't be a mo[ment]
07   CAL:                    [A:bs]olutely.=Now I don't know if she works
09   CAL:     at Pipitea or Kelburn but I'm available to go to either.
10            (0.9) ((typing/.hh))
11   REC:     o:ka::y so >its'< just when she's next available?
12            °did you s[a:y or:°         ]
13   CAL:               [yeah >that'd be< g]reat thank you.
14            (0.2)
15   REC:     °so°=
16   CAL:     =Hopefully it's hh .Hhh[hh                 ]
17   REC:                           [>i-probably gonna be] the< first
18            week of:: hh (0.4) .h (0.3) Decembe(h)r.
```

Here, caller Maya makes an implicit request for an appointment with a particular clinician. Packaged within this request is information about the kind of appointment sought and with whom. At line 05 the receptionist receipts the request with "°o:kay su:re°". Temporarily disengaging, "just going to bring her template up ↑here↑" (line 05) the receptionist moves towards granting the request. As the action of looking at the doctor's template is part of the business of booking an appointment the receptionist's turn signals that they are going to grant the request (Lindström, 1999). This also shows that the category entitlement (Sacks, 1972) invoked by the caller, which is afforded to medical doctors, legitimates the current request. The information the caller packages in their request both shapes and constrains the relevant next action for the receptionist. Facilitated by the caller narrowing down 'where' to look for an available appointment, the receptionist furthers the interactional project in the next turn.

Re-engaging in the interaction, the receptionist topicalises the appointment timeframe at lines 11-12. Doing a request for confirmation that prefers a 'yes' answer "so >it's< just when she's next available?" (*it* being the appointment), the receptionist displays a preference for the caller to confirm. However, in another request for confirmation, "°did you sa:y or:°" (line 12) the receptionist deletes this preference leaving an alternative timeframe open to the caller (Stokoe, 2010). This shows the receptionist's orientation to the timeframe as something that is a possibly delicate matter for the caller.

The caller confirms that she would like the next appointment, assessing it as "great" (line 13). Although, with talk having lapsed the caller begins a turn "hopefully it's" (line 16), that is abandoned with a sigh ("hh .Hhhhh") in a display of resignation (Hoey, 2014). Recycling the receptionist's indexical *it* for the appointment, the caller's turn is projectably on the way to establishing the timeframe within which they hope to see the doctor. Recognising this, in overlap with the caller's in-breath the receptionist does an informing of the when the next available appointment is (lines 17-18) – approximately two weeks from the date of the call, a timeframe which is jointly oriented to as too-long.

Constructing the conditions of granting the request in terms of the doctor's availability, the receptionist shows how they are constrained by the conditions of the request. In one way, the practical problem of when to book the appointment is resolved by the caller requesting a specific clinician. So, the receptionist progresses the request in a way that is most fitted to the caller's priority (the clinician) yet manages the wait-time dilemma as best as possible.

The final extract in this section demonstrates how a caller's display of knowledge as a service seeker is consequential for how the receptionist progresses their interactional project. Here, the caller's request constructs urgency as a precondition to getting an appointment. The receptionist grants the request in the next turn.

Extract 4.3 Emergency appointment nurse

```
Ashley: 071219

01   CAL:   hi: um i was wondering if i was: able to be connected one
02          of the nurses #the um: emergency appointment ones. .hh at
03          all=or um called by one of them,
04          (0.5)
05   CAL:   asap?
06          (0.2)
07   CAL:   .skuh=
08   REC:   =oh:kay i can get a triage nurse to give you a call? A:h
09          >just one moment?<
10   CAL:   °.shih #yep#° hh
11   REC:   can you just give me your ID number ↑please?
```

Packaged within this request are details of what kind of action is sought, and when. The caller explicitly requests to "be connected" to "one of the nurses the um emergency

appointment ones" or alternatively "called by one of them" (lines 01-03), topicalising urgency. By doing a categorisation "emergency" (line 02) the caller invokes the seriousness of their problem. Adding an increment (Schegloff, 2016) "asap?" (line 05) the caller upgrades the seriousness and urgency further. In constructing the request in this way, the caller displays their familiarity with the processes at Mauri Ora. Crucially, by asking not for an appointment but to be connected to a nurse displays knowledge of the services on offer. This caller shows that they know the way to access an appointment "asap?" is through the triage nurse, and so formulates their request to be fitted to this process. Demonstrating their competency as a service seeker, the caller constructs *urgency* as a precondition and constitutive rule (Garfinkel, 2019) for getting triaged.

In turn, the receptionist meets this detailed request with an offer "oh:kay i can get a triage nurse to give you a call?" (line 08). Displaying their orientation towards granting, the receptionist is responsive to the caller's display of knowledge and progresses the interactional project swiftly. Reformulating *emergency appointment nurse* as "triage nurse", the receptionist demonstrates their understanding of the caller's formulation of the service and shapes it into the institutional language and an action that they can progress. Upon acceptance from the caller "#yep#" (line 10) the receptionist moves to gather institutionally relevant information (line 11) marking that they are progressing the granting of the request.

These cases showed how receptionists responded to various requests in a way that progressed the interactional project of the caller promptly. The following analyses, however, show cases where the help is not granted nor grantable in the here and now.

Urgency as a resource to progress action

Urgency is used as a resource to manage the practical problem of long appointment wait times. The granting of requests for an appointment today is deferred in time and to the deontic domain of a medical expert (triage nurse). The analyses show that and how receptionists shape and transform requests, constructing the contingencies under which the requests can be granted – using urgency as a resource to do so. The analyses thus demonstrate the receptionists' skills in providing solutions to requests that they are institutionally constrained from granting here and now.

Extract 4.4 presented below, shows a case where the caller requests an appointment, and the receptionist topicalises urgency. The outcome for the caller here is a booked, routine

appointment. This case shows that one way to manage a request is to make it 'grantable' by booking with a nurse (as 4.1 showed) demonstrating again the locally produced preference for granting requests in the next turn. This caller however wants to see a doctor and so the problem of *when* comes to the fore. With no specifying parameters this request presents a clear case for demonstrating the orderly manner by which receptionists use urgency as a resource to progress the requested action.

Extract 4.4 Wednesday next week

```
Kieran: 140219

01  CAL:    yeah gidday >i was hoping i could< make an appointment,
02          (0.4)
03  REC:    ↑yep↑ with a nurse doctor o:r a counsellor.
04          (0.4)
05  CAL:    .hh a:h doctor pleas(h)e hh
06  REC:    °with a doctor alright.° h and was it something
07          (.) <quite urge:nt?=we're just currently booking fro:m
08          wednesday next week h
09          (0.3)
10  CAL:    .h UM i can do like (>any</yeh) wednesday hh
11          (0.2)
12  REC:    ↑wednesday↑ cool i'll have a loo:k
```

Here, the caller makes an explicit request for an appointment. As in extract 4.1, the receptionist's responsive turn requests specification regarding whom the caller would like an appointment with – "with a nurse, doctor o:r a counsellor." (line 03). At line 05 the caller selects 'doctor', after which the receptionist recycles their own previous formulation 'a doctor' (at line 03) to construct "with a doctor" (line 06). Grammatically fitting their talk to the caller's request, the receptionist retrospectively transforms the request into one that can be parsed into *I was hoping I could make an appointment with a doctor*. This is a pragmatic action that manages the grantability of the request – what type of clinician the caller wants to see is consequential for when and how the appointment is booked.

With a request for confirmation about the nature of the caller's problem, the receptionist constructs the conditions under which an appointment with a doctor can be granted "and was it something <quite urge:nt?" (lines 06-07). By beginning their turn with an 'and-preface', the receptionist marks this question as routine in character and related to the sustained course of action that is granting the appointment request (Heritage & Sorjonen, 1994). The receptionist topicalises urgency as an institutional category that has relevance for the appointment request. The request for confirmation is quickly followed with an informing

"we're just currently booking for next Wednesday" (line 07-08). Double-barrelled in terms of action, this unit of talk both accounts for why the receptionist has asked about urgency and informs the caller of the timeframe for a booked appointment. So, in one unit of talk, the receptionist constructs access to an appointment before Wednesday next week as something that is contingent upon the caller having an urgent problem. Furthermore, urgency is topicalised *after* the caller has specified they want to see a doctor, demonstrating the receptionist's practical management of the limited availability of appointments.

In this turn (lines 06-08) the receptionist pre-empts the possible rejection of an offer for an appointment one week away, Thus, they display an orientation to the long wait time as resulting in non-urgent problems being treated or described as urgent. Moreover, the order of the turn displays the receptionist's understanding that a non-urgent appointment may be more fitted to the caller's request. The receptionist designs their turn so that the non-urgent timeframe is at the end (turn final position). The principle of contiguity means what is presented last is more likely to be responded to. (Sacks, 1987). Thus, they display a preference for the caller to select next Wednesday as an acceptable appointment timeframe. In this turn, the receptionist manages the practical wait time problem by giving the caller an alternative way to access care if they need it.

By means of confirming that next Wednesday is suitable for an appointment, the caller concurrently discounts urgency as relevant to their request. However, the caller's turn does have features of a dispreferred response, interrupting contiguity – with a 0.3 second delay (line 9) and "UM" preface (line 10). This means that the first part of the turn is not the conditionally relevant response, and when that does come, it is downgraded – "I can do (any/yeh) Wednesday" (line 10). This suggests there is some trouble with the parameters set – while the caller does not have an urgent problem, they align with the receptionist's orientation to the week-long wait time as troublesome. Now grantable, at line 12 receptionist recycles "wednesday", assesses it as "cool" – using this assessment to pivot to the next action which is to find an available appointment. That the receptionist then moves to 'look' supports the claim that these questions serve a pragmatic function. They gather information relevant to locating an available appointment time and are asked in service of granting the appointment request.

The following case extract 4.5, is another where the caller requests an appointment, and the receptionist topicalises urgency in response. This caller specifies that they want to see

a doctor in their request. This case shows that when booking with a nurse is not possible, another way to manage a request is to make it 'grantable' by shaping it into a request for an urgent appointment.

Extract 4.5 A little bit more urgent

```
Nicholas: 140219

01  CAL:    .hh hi i was calling to see if I would be able to: get
02          a um (.) doctor's appointme:nt?
03          (0.2)
04  REC:    ↑yeah definitely↑ um so we're currently booking for
05          the: .h for <next week> the wednesday the twentieth,
06          ↑is that okay or is↑ it something more urgent.
07          (0.8)
08  CAL:    .h it would be >a little bit< more urgent ye::ah
09  REC:    °yehp° cause I can pop you on the telephone triage
10          line,.hh so a nurse will >give you a ca:ll talk to you
11          over the l-um pho:ne and see if an- um if she can
12          bring you in for an appo:intment? .hh what's your
13          student ID.
```

The caller specifies they are seeking to book a doctor's appointment (lines 04 -06). This occasions a notably similar response from the receptionist as the turn discussed in extract 4.4. However here, with the question of what type of clinician to book with resolved, the receptionist moves directly to establishing when the appointment is required.

Furthering the interactional project, the receptionist constructs the parameters within which a doctor's appointment is available. The turn begins with an affirmative acknowledgement "↑yeah definitely↑" (line 04) signalling a promise to grant (Lindström, 1999). The turn also informs the caller of the timeframe for booking an appointment "so um so we're currently booking for the: .h for <next week> the Wednesday the twentieth," (lines 04-05) and a request for approval "↑is that okay…" (line 06). Finally, doing a request for confirmation, the receptionist offers an alternative in the case that Wednesday is not okay "…or is↑ it something more urgent" (line 06). The receptionist topicalises urgency, and again constructs the availability of an appointment before next Wednesday as being contingent upon the caller having an urgent problem.

The receptionist constructs it as preferring a confirmation of urgency. Preferring a 'yes' answer, "something" (line 06) conveys the stance that the caller has a legitimate problem. Locating the question about urgency in turn final position the receptionist makes it easy for the caller to do a confirmation (Sacks, 1987). Thereby the receptionist displays their

understanding that it may be the case that the caller has an urgent problem. In doing so, they orient to the week-long wait time as too long such that an offer of the next available appointment is likely to be rejected. As a whole, the turn constructs the conditions that make the request grantable and is oriented towards progressing the caller's interactional project.

Confirmation that the caller's problem is urgent enables the receptionist to progress the course of action. There is a notable gap of 0.8 seconds before the caller responds (line 07). When the response comes (line 08), is it very mitigated and hedged – a downgraded claim to their problem as belonging in the institutional category of urgent (Sikveland & Stokoe, 2017a, Sikveland et al., 2019). Nonetheless, the confirmation of urgency means that the receptionist can progress the granting. They do this with an offer-explanation package (lines 09-13), explicitly outlining how the offer furthers the caller's interactional project. The turn begins with the offer, in the form of something the receptionist can enact "I can pop you on the telephone triage line,". The institutional terminology 'telephone triage line' is treated as something explainable, and immediately followed by the explanation. That the receptionist treats this explanation as relevant, displays their understanding of how knowledgeable the caller is as a service user, in contrast to extract 4.3 where triage was not explained.

Moreover, fitting the offer to the request, the upshot of the explanation is that *the nurse will see if she can bring you in for an appointment* (parsed). The receptionist treats the offer as not requiring acceptance from the caller and continues to hold the floor to request the caller's student ID (line 12), indicating that they are enacting the offer. Demonstrating their competence in managing a request that was not straightforwardly grantable, turn by turn the receptionist shapes a request for a doctor's appointment into a referral to the triage line.

The final case presented below shows another request for an appointment. This time the caller specifies they are seeking a same-day appointment. This case shows another way that receptionists are responsive to callers' requests, and oriented towards granting them in the most efficient way.

Extract 4.6 Something quite urgent

```
Danielle: 071218

01  CAL:  .tch hi there I was just ↑wondering if I could get an
02        appointment today.
03        (0.4)
04  REC:  yeah was it something quite urgent?
05  CAL:  um ye:ah (0.2) [y(hi)eah .h   ]
06  REC:                 [cos I can pop] you on the telephone
07        triage line and that's where a nurse will give you a call
08        assess you over the phone and see if they can bring (.)
09        you in for a priority appointment,
```

The caller in this case specifies that they are seeking an appointment for today (lines 01-02). The receptionist's following turn is designed to progress the caller's interactional project in the most efficient manner. Like the previous two cases (extract 4.4; extract 4.5) the turn begins with an affirmative acknowledgement "yeah" (line 04) that indicates a promise of incipient granting (Lindström, 1999). Without pause, the receptionist does a request for confirmation "was it something quite urgent?" (line 04) that also legitimates the caller as having a problem.

In asking this question immediately after the request, the receptionist treats timeframe in the request as having resolved the need for to ask for specification on when and with whom the appointment should be. The timeframe (today) denotes one within which an appointment (typically) is only accessible in urgent circumstances. What the receptionist treats as the appropriate next action to progress a solution, is to establish whether urgency is a relevant matter for the caller. Urgency is again drawn on as category of problem, and access to a same-day appointment is constructed as contingent on the caller having an urgent problem. The receptionist does this in the next turn after the request, supporting the claim that receptionists are oriented to a preference to grant requests and grant in the next turn where possible. The question thus furthers the interactional project while also constructing urgency as a condition under which the request can be granted.

Moreover, in asking a simple request for confirmation, preferring a 'yes' answer, the receptionist treats an aligning second pair part as enough to establish urgency and progress to an offer. The caller confirms that they do indeed have an urgent problem (line 05). In the following turn (lines 06- 09) the receptionist moves to the next activity, packaging together an explanation and offer of what can be done to grant the request (as in extract 4.5), which is to refer the caller to the nurse for a triage assessment. Explicitly tied back to the request "for

a priority appointment," (line 09) the receptionist shows how their offer is fitted to and progresses the request.

Summary

The analysis presented in this chapter has shown how receptionists grant appointment requests and progress action to provide callers with some way to access health care. I have shown that callers make requests for appointments in a variety of ways that make them more or less grantable. When requests can be granted in the next turn receptionists orient to a preference to do so. Using the information conveyed in callers' requests, receptionists demonstrated their understandings of callers' experience with the service and orientations to urgency, moving to grant in their following turn. When callers made appointment requests that receptionists could not straightforwardly grant, receptionists used urgency as resource to progress the action and provide the callers with a solution to their request. They accomplished this by requesting confirmation in a way that constructs the parameters within which an appointment can be accessed. In doing so, receptionists demonstrate their skill in making sense of what a caller is asking for and shaping the progression of the call to provide the best course of action for the caller. Even though appointments are limited, receptionists showed their orientation towards being supportive to the needs of patients by using urgency to construct the conditions under which a request for an appointment could be progressed. This suggests, that far from limiting access to care, receptionists are oriented towards doing what they can to facilitate access to care.

Chapter 5: Disclosure and solicitation of medical information.

The prior chapter showed that receptionists orientated towards granting requests even when it was not straightforward to do so. This chapter focuses on another dilemma receptionists manage: seeking and responding to health-related information. The dilemma this raises for Mauri Ora's receptionists is that they are not medically qualified, in the way that health professionals are, to manage medical information or make clinical decisions but are required to do so as part of the work of triaging callers. I examine how a description of the medical problem is disclosed or solicited, and how receptionists respond to the information.

Other research with medical receptionists reflects this dilemma in a range of ways. Receptionists report that making these decisions is a great responsibility (Neuwelt et al., 2016), but soliciting information is difficult because patients may be reluctant to disclose to receptionists (Gallagher, Pearson, Drinkwater, & Guy, 2001; Sikveland & Stokoe, 2017a, Sikveland et al., 2019) who they treat as acting outside their remit (Arber & Sawyer, 1985; Paddison et al., 2015). Sikveland and colleagues (Sikveland & Stokoe, 2017a, Sikveland et al., 2019) concluded that in triaging patients, it was ineffective for receptionists to ask about routineness, or contrast routineness with urgency and suggested rather that receptionists solicit an account of the problem.

In this chapter I will show 8 extracts in which the caller's medical problem is disclosed or solicited. Firstly, I present 3 cases where callers disclose their problem as part of the reason for calling. Then, I show a case where the receptionist explicitly formulates 'the rule', clearly linking the triage referral to having symptoms. Finally, I present 4 extracts where the receptionist solicits a problem description.

The analytic work of this chapter is informed by and develops further understanding of how receptionists manage health related information when triaging callers. It also shows that issues of accountability and problem presentation in the medical context are important when people are seeking to access health care. I show how *the patient's problem* (Halkowski, 2006; Heritage & Clayman, 2010; Heritage & Robinson, 2006) manifests in the talk of callers to Mauri Ora, where the contingencies and stake are differently relevant than in the doctor's office.

Disclosure of problem as part of the initial request for an appointment

In the first case, the problem description is embedded in the caller's first turn request. This case demonstrates the caller orienting to a problem description as a relevant part of their request for help, housing medical information within the request.

Extract 5.1 problems with the pill

```
Michelle: 101218

01  CAL:    .hh <hi ((NAME))> um I'd just like to book an appointment
02          with one of the doctors in regard to my (.) pi:ll
03          i:'m experiencing a few problems (.) with it so: i'd like
04          to >just< have a chat with one of the doctors °please°,
05          (0.2)
06  REC:    ↑yeah↑ defi↑nitely: what was yo:ur student id?
.
.           (( 15 lines omitted gathering information))
.
21  REC:    =okay so just keep your phone nearby, i've popped
22          you on the telephone triage ↑list↑ and someone will
23          be in touch to um talk through that with you.
```

The request at lines 01-04 is contains medical information. Firstly, the caller specifies that their request is for an appointment with a doctor (lines 02-03). Justifying the request, the caller describes their medical problem "…in regard to my pi:ll i:'m (.) experiencing a few problems (.) with it" (lines 04-05) . Further, the caller describes their problem in way that demonstrates knowledge of what the problem is and that it is obviously doctorable (Heritage & Robinson, 2006). Thus, they present themselves appropriately seeking medical advice on it. In embedding this description in their request, the caller treats it as directly relevant to making the request.

The problem description in the request provides sufficient information for the receptionist to grant the request immediately (line 06), with an affirmative acknowledgment and the move to requesting the caller's student ID number. The description makes available sufficient information for the receptionist to infer that the caller meets the requisite conditions for referral to the triage nurse. After this information gathering sequence, the receptionist summarises her referral (lines 21-23) confirming that the caller will be contacted by a triage nurse regarding a priority appointment and explicitly tying the nurse's call to helping with the problem. Using the past tense '*I've*' at line 21, the receptionist designs their turn to convey that linking the caller to triage has been enacted (Hofstetter & Stokoe, 2015). This case demonstrates that a problem description offered by the caller in the reason for calling

provides the receptionist with information to immediately treat the request as both urgent, and sufficiently detailed to progress a referral to the triage nurse.

Another instance of medical information that is disclosed in the caller's first turn is presented below. Here, Ana presents her problem in a turn that serves as a request. Providing a problem description in the first turn demonstrates its relevance to the caller.

Extract 5.2 swollen and red and irritated eyelids

Ana: 071218

```
01    CAL:   .hh I have a question u:m:: (0.6) I might have to
02           see: maybe a doctor?
03           (0.2)
04    CAL:   >i'm a student at Victoria:
05    REC:   [↑yeh   ]
06    CAL:   [.hh bec]ause my eyelids u:m: >like for the last three
07           weeks I thought it's gonna go away but u:m my eyelids
08           have been like a >little bit< swollen and red and
09           irritated?
10           (0.3)
11    REC:   ok ↑what's your s[tud]ent id. ((muffled sound))
.
.            ((17 lines omitted, gathering institutionally
.             relevant details))
.
28    REC:   alright ana perfect I'll just double check your contact
29           number was it still seven one one.hh five zero six
30           four two one?
31           (0.4)
32    CAL:   yes
33    REC:   .hh ok so what I'll do is pop you down on the telephone
34           triage line, .hh and that's where one of the nurses will
35           give you a ca:ll um >assess you< over the phone and see
36           if they can bring you in for a priority appointment, to
37           get your eye looked ↑at↑ .hhh um so just keep your phone
38           nearby and one of the nurses will be in touch.
```

The target of analysis is the talk at lines 06-09. Prior to this, the caller has framed their reason for calling as requesting advice (line 01-02), displaying uncertainty about whether their problem warrants a visit to the doctor in terms of seriousness and urgency. Taking a narrative format, the turn recounts the duration and persistence of the eye problem, the caller orients to presenting themselves as having reasonably sought medical care by demonstrating appropriate monitoring of their body (i.e. neither too attentive nor too lax) (Halkowski, 2006). The caller further builds their problem as a doctorable one with the insertion of a display of troubles resistance (Heritage & Robinson, 2006) – they have waited to see if the problem would resolve itself and is only now seeking medical help. They

describe symptoms that together constitute an out-of-the-ordinary, persistent and thus justifiably doctorable medical problem.

By moving directly to the offer, summary and next steps the receptionist treats the contingencies under which a referral to triage can be made as fulfilled and accounted for by the medical information provided in the request. Shown at lines 33-38 the receptionist properly grants the request in a turn that does multiple actions. It does an offer and explanation of the triage service as a solution to the request and advises on the next steps the caller should take to access the solution. The solution is fitted to the request with an explanation of how it relates to what the caller has asked for. The receptionist explains that the nurse will assess the caller for a "priority appointment", recycling the information provided in the caller's problem description, to get the caller's "eye looked at" (lines 36-37) .

Below is a case where the caller has made a request for a same-day appointment that has been rejected. Here, the problem description is done in response to a request for confirmation, after the rejection. Nonetheless, occurring early in the call demonstrates the caller's orientation to it as being relevant and important to the request itself.

Extract 5.3 nurse suspects its strep throat

```
Tasha: 071218

01  CAL:    Hi i was ↑just wondering if↑ you have any appointments
02          after three thirty today,
03          (0.7)
04  REC:    .tch .hh we are actually fully booked for ↑doctors
05          a:n: (.) doctors today >was it for a doctor
06          that you wanted?
07          (0.2)
08  CAL:    um yeah cos i rung a nu:rse this morning and °she:
09          suspects° that i have tonsillitis or strep throat,
10          (0.5)
11  REC:    yea[h?]
12  CAL:       [ u]:m and she said I should see a doctor asap about it,
.
.           ((30 lines omitted, REC & CAL establishing if CAL spoke to
.             Mauri Ora triage nurse, that she is not already on triage
.             list, and clarifying the triage process))
.
42  REC:    =is that okay? i'll put you on the list for a
43          nurse to call you?
44          (5.0)
45  CAL:    okay >yeah no that'll< be good
46          (0.5)
47  REC:    so just give me your i:d number.
```

Oriented to granting the request, the receptionist requests confirmation (lines 04-06), this turn is designed to favour a 'yes' answer. By doing this immediately after rejecting the request, the receptionist drives forward the trajectory for progressing the caller's interactional project, rather than flatly rejecting it. The caller confirms they do want to see a doctor, and then accounts for why that is justified (lines 08-09). It is here that the problem is presented. The problem is delivered as a candidate diagnosis of "tonsillitis or strep throat" (line 09). The caller supports their claim to this diagnosis by invoking the medical authority of a nurse. Framing the diagnosis as belonging to the nurse, the caller thereby mitigates their accountability for seeking same-day care (Heritage & Robinson, 2006). The caller then explicitly links the presence of this problem to justifiably requesting an urgent appointment (line 12). The nurse's category entitlement as a medical expert is invoked to mitigate responsibility for the request (Sacks, 1972), and upgrade its seriousness and urgency.

The caller's request is justified by the description of their problem. In presenting the problem when the request's grant-ability is at stake, the caller explicitly ties its relevance to the request. After some trouble in establishing whether the nurse was from Mauri Ora or elsewhere and whether the caller has already been triaged, the receptionist offers triage (line 42) and moves to enacting the offer (lines 47) without further inquiry into the caller's problem. This shows that the problem description has fulfilled the contingencies required for referral to triage.

So far, the cases analysed have shown evidence that both callers and receptionists orient to the relevance of some kind of problem description to request for same-day care, and that once it is provided a referral to triage can be offered.

Receptionist asks a follow-up question to an initial request

The following case explicitly demonstrates this normative orientation to the importance and relevance of a problem description. In this case, the caller's initial request has been for information on the availability of appointments with a particular clinician. The receptionist provides the information and offers the next available appointment. This is evidently too far away for the caller's needs and we join the interaction where he rejects the offer.

Extract 5.4 surgery on the shoulder

```
Christopher:071218

01  CAL:    o:kay: u:m:
02          (1.4)
03  CAL:    .tchh >.tch .tch< °.tchh >.tch .tch<° (.tchh/.snhh)
04          ah am i able to s:peak to a triage nurse.
05          (0.2)
06  CAL:    <just to see if it's worth: (.) u:m
07          (0.7)
08  REC:    .snuh .hh [do you feel like it's something medically]=
09  CAL:              [  (coming in)  (            )  someone  ]
10  REC:    =urgent do: you:
11          (0.5)
12  CAL:    >well yeah< i just had a surgery a- a- bout (two/three)
13          weeks ago on my shoulder
14          (0.3)
15  REC:    oh: okay
16  CAL:    u[m  ]:
17  REC:     [yup]=
18  REC:    =i'll pop you on the list if you've got
19          some symptoms .h okay what's your ↑id number?
```

Displaying knowledge of the service, the caller uses institutional language "triage nurse" in their request (line 05). Moreover, they ask not for an appointment sooner, but the institutional solution which is to speak to a triage nurse. The receptionist's (delayed) response at line 08 and 10 does two actions. Like the cases examined in chapter 3, it explicitly builds "something medically urgent" (lines 08-10) as the category of problem that access to the triage nurse is contingent on. It also seeks to establish that the caller's situation meets the requisite conditions for a referral to triage by soliciting a confirmation that the caller's problem is in this category. In terms of its design, the question is again formatted as preferring a 'yes' response. The turn final tag question "do: you:" (line 10) orients to providing a confirmation of whether the problem is medically urgent as within the caller's epistemic domain (Heritage, 2002).

The caller does a problem description which is evidence they treat it as relevant to their request to speak with a triage nurse. The caller does an account (line 12-13), expanding on the yes/no terms of the question, giving information about what their problem is. As the receptionist has explicitly constructed access to the triage nurse as contingent on having "something medically urgent", the caller makes use of the affordances of having the conversational floor to justify their request (Heritage & Robinson, 2006).

The receptionist comes in in overlap (line 17) to signal they will grant the request "yup" (Lindström, 1999). Again, the contingencies under which the request will be granted are explicitly constructed in the immediately following talk. The receptionist explicitly puts on the record that the triage referral is contingent "if" (line 18) on the caller having "some symptoms" (line 19). That this is for the record is evident in that the receptionist's turn continues through to a request for the student ID without space for confirmation of symptoms by the caller. In designing their turn this way, the receptionist explicitly formulates their transformation of the caller's description into one from which symptoms can be inferred.

By constructing triage referral as contingent on the caller's problem being "something medical urgent" and having "some symptoms" , the receptionist brings to the surface the relevancies that have been oriented to in all the prior cases. The receptionist explicitly constructs that the condition for getting triaged is having 'symptoms'.

Receptionist asks about the problem

A second way that receptionists gather the medical information required to make a triage referral is by asking about what the problem is. This question frequently occurs at the end of the information gathering activity, and only in calls where medical information has not already been disclosed. The following analysis presents four extracts where this occurs. The analysis considers aspects of the sequential environment and turn design that show receptionist's management of their rights to medical information. The analysis also considers why and how callers respond differently. In the first two instances, callers answer in a straightforward matter, while in the remaining two, callers' responses indicate trouble with the question.

The first extract presented below is taken from a call in which the caller has requested a same-day appointment and confirmed urgency (shown in extract 4.6). Triage has been proposed and we join the interaction towards the ends of a series of questions gathering institutionally relevant information. Asking about medical information in this location shows a preference for self-disclosure. The analysis shows how the caller aligns with the turn design, while orienting to their accountability as a would-be patient.

Extract 5.5 uti

```
Danielle: 141218
01    REC:   °okay cool and was° your contact number still (.) seven
02           one one five two four seven zero zero seven?
03           (0.5)
04    CAL:   Yep that's correct
05           (0.2)
06    REC:   °alri::ght° and what are you experiencing at the moment
07           (1.0)
08    CAL:   UM: a uti.
09           (0.3)
10    REC:   .tch °oh kay° so just keep your phone nearby and one of=
11    CAL:    [the nu-]
12    REC:   =[yeh    ] um: .tch nurses will be in touch
```

The receptionist's medical information solicitation is done at line 06. It is 'and' prefaced, marking this question as part of ongoing of information gathering activity (Heritage & Sorjonen, 1994). They treat what could be hearable as a question about medical information as functionally being an information gathering question. Thus, the receptionist manages their rights to ask about medical information by marking this question as a routine part of granting the caller's request. Making the request at the end of this activity, the receptionist not only ties the request to a routine activity but shows that they have left it to the last possible moment to ask about medical information. This points to a preference for self-disclosure.

The receptionist further manages the dilemma of asking about medical information by framing the information as something the caller has full access to. First, using the *wh-*interrogative format, the receptionist takes a low epistemic stance on the requested information (Heritage, 2002). Second, embedded in the design of their question (line 06) is the assumption that urgency denotes a medical problem they are presently experiencing, and this evokes their epistemic status as the *experiencer* (Sacks, 1984). Finally, the time reference "at the moment" (line 06) locates the experience in the present and also constrains what a fitted answer can be. Therefore, the receptionist frames the symptoms as something which that caller has an *epistemic responsibility* (Stivers, Mondada, & Steensig, 2011) to speak on.

By delaying the conditionally relevant response, the caller displays an orientation to the question as troublesome. The caller's response signals trouble and contains features that would normally be expected of a dispreferred response (Schegloff, 2007). There is a gap of 1 second that delays the caller's response (line 4). It is further delayed by a markedly loud and

elongated "UM:" (line 08), possibly in orientation to the delicacy or preciseness of the forthcoming information (Lerner, 2012). The next turn proof confirms the caller's understanding of the receptionist's turn as a request for information. The information "a uti." is delivered in the form of a candidate diagnosis (line 08). Being a routine acute problem, a UTI (urinary tract infection) is one that can recognisably be referred to by its vernacularized name, neatly packaging a set of relatively common symptoms and experiences (Heritage & Robinson, 2006). 'UTI' invokes common-sense knowledge that such an infection can require urgent medical care (e.g. antibiotic treatment, can lead to severe kidney infection if untreated). By referring to their problem this way, the caller assumes that the receptionist shares this knowledge and will understand it. The caller thus legitimates the request by doing an account and yet is packaged as information.

The design of the receptionist's request, and the construction of the caller's problem facilitate the smooth progression through this sequence and into to the next phase of the call. Ultimately, the caller's response aligns with both the design and action of the question, providing a straightforward answer that gives the receptionist the details they need on the record for a triage referral.

Below is presented a case in which the receptionist asks the very same question. Here though, the caller responds with a problem presentation. Caller Nicholas has requested an appointment and confirmed that it is for an urgent matter but not yet disclosed what the problem is. The analysis shows how and why the caller produces an answer that is not fitted the with question design.

Extract 5.6 pretty intense headaches
```
Nicholas: 141218

01    REC:  ↑cool and was your contact still↑ two seven two
02          three seven nine (0.2) five three six four?
03          (0.7)
04    CAL:  yep. (.) that's it.
05          (0.2)
06    REC:  ok and >what are you< experiencing, at the moment.
07          (1.2)
08    CAL:  U:hm: (.) ah (.) pretty (0.8) pretty intense
09          Headache(hh)s ahm PROBABLY A FEVER but I (.) don't have
10          a way of checking (0.7) u::hm (0.7) .t cold sweats,
11          (0.2) like the last two nights I've gone to sleep
12          and I've been feeling quite cold but .hhhh
13          very sweaty and right now i'm (0.4) at a normal
14          temperature an- (0.8)
15    REC:  °yep a[lright° ]
16    CAL:        [sweating] a lot
17    REC:  okay- i'll just pop you onto their line, so just keep
18          your phone nearby, .hh and one of the n[urses will] give=
19    CAL:                                          [okay     ]
20    REC:  =you a call
```

Here, at line 06 the receptionist requests information about what the caller is experiencing. Like the receptionist's preceding question (lines 01-02), it is and-prefaced. Thus, it is marked as part of the ongoing activity of gathering institutionally relevant information (Heritage & Sorjonen, 1994). The same question as that asked in extract 5.5, the receptionist again designs their turn to make conditionally relevant response something that the caller has full and primary epistemic access to (Sacks, 1984).

In this case, the caller orients to the question not as a request for information, but as one that challenges the doctorability of their problem. In the first instance, the caller's response has features of a dispreferred response, indicating trouble in formulating an answer. The talk is delayed by a silence of 1.2 seconds (line 07). When the caller begins speaking their talk contains more feature of a dispreferred response – an um preface, several pauses, and a word-search "U:hm: (.) ah (.)" (line 08) – that further delay the relevant response.

The caller answers with a narrative format, problem presentation (lines 08-14). First, the claim to be experiencing "pretty (0.8) intense Headache(hh)s" (lines 08-09), a vernacularised symptom category. The lexical choice of 'intense' here is an assessment, functioning to make a case for the warrantability of their request as the headaches are

constructed as worse than one would normally experience. An extreme case formulation, this assessment is typical of those made to justify a claim (Pomerantz, 1986). They provide a downgraded candidate diagnosis "probably a fever" (line 09). Crucially however, they provide a caveat that mitigates the diagnostic proposal "I (.) don't have a way of checking" (lines 09-10). Following this, they present evidence in support of the claim to a fever despite being unable to confirm it. "Cold sweats" (line 10) and sweating at a normal temperature justify the claim to have a fever.

Embedded in this presentation of evidence is a displays trouble's resistance, (line 11-12) showing that they have not sought care at the first sign of a problem but only because the problem has persisted. In this detailed problem description, the caller displays that they have interpreted the question as one that makes relevant an account of the legitimacy and doctorability of their problem. The caller orients to their access to an appointment as contingent on how they answer this question. Having the conversational floor enables the caller to present their problem in accordance with their own agenda (Heritage & Robinson, 2006), which is to present themselves as a would-be patient with a legitimate and doctorable problem. This shows one way that trouble can arise when receptionists ask about medical information.

At line 15, following a pause in the caller's talk the receptionist takes up the opportunity to indicate that the story so far is sufficient for the record. Following this, the receptionist sums up the next steps, confirming that the nurse will be in touch (17-20).

The following extract demonstrates how getting the problem on the record unfolds when the caller proposes a vernacularized candidate diagnosis. This case, however, plays out differently to the prior one. The analysis also shows how and why the caller has trouble formulating a response.

Extract 5.7 chest infection

```
Jenna: 141218

 01    REC:    great a:nd (1.4)
 02    CAL:    .shih
 03    REC:    um what would the u:m nurses be calling you for:
 04            (.) the reason for your calling
 05            (0.7)
 06    CAL:    um (0.7) I think I #might have# a chest infection or
 07            something?=
 08    REC:    =great chest infection? .hh=
 09    CAL:    =yea[h: ]
```

As in the previous case, the receptionist's request for information (lines 03-04) is and-prefaced and so characterised as another in the series of information gathering questions (Heritage & Sorjonen, 1994). This question occurs in the last possible position before the receptionist moves to the activity of summarising the next step, pointing again to the preference for self-disclosure. The receptionist repairs their question, displaying trouble in formulating it. The first indication of possible trouble is a long pause of 1.4 seconds (line 01) between the 'and' and the receptionist's continued turn. This could either signal trouble in formulating the question, or that the receptionist is engaged with activity on their computer.[5] When the talk resumes, 'ums' and pauses interrupt its smooth delivery (line 03). The initial formulation "what would the u:m nurses be calling you for" at line 03 is immediately repaired, reformulating the question. In repairing their talk this, the receptionist orients to the dilemma of asking about how to ask about health information. Ultimately, the receptionist settles on a formulation that locates the relevant answer more clearly in the caller's domain of knowledge (Raymond & Heritage, 2012).

Like extract 5.5 some trouble in responding to the question is apparent, with features of delay typical of a dispreferred response (Schegloff, 2007). In addition to the gap of 0.7 second (line 05) the caller displays further trouble in producing the conditionally relevant response. When it comes (lines 06-07) it is prefaced with an "um" that is followed by another silence of 0.7 seconds. The requested information is presented as a candidate diagnosis "chest infection" (line 06). This candidate diagnosis packages a set of symptoms into a discrete, vernacularised unit of information that is captures its recognisability as an illness

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[5] After confirming the patient's contact information is correct, the next step on the patient management software is to close the patient's profile in order to return to the appointment schedule, where a note to the nurse about the nature of problem can be made. Transitioning between these windows can take a moment to process.

(Robinson & Heritage, 2006) and invokes cultural understandings of seriousness and urgency.

Although the caller does provide the requested information, they orient to some trouble with presupposition of the receptionist's question (Stivers & Hayashi, 2010). The candidate diagnosis is very mitigated and hedged in its delivery – displaying resistance to claim the diagnosis "I think I #might". Further downgrading her claim to the diagnosis, the caller says "or something" leaving the diagnosis open to a class of problems. This shows that the trouble is in their rights to claim knowledge of medical categories. Thus, they are not claiming unequivocally to have a chest infection but rather that the problem is 'something' in the category of illnesses like chest infections. Therefore, while the caller does answer the question in a relatively straightforward manner – and provides the requested information – they display a degree of resistance to its presupposition.

Nonetheless, producing a description of their problem when asked for *the reason for calling* demonstrates their understanding that disclosing their problem is relevant to their project of requesting a same-day appointment. Moreover, in producing a problem description as the response to the question, the caller also orients to the shared understanding that to access same-day care means you must show that you a have current medical problem.

In third position, the receptionist re-orients to the action of their question as information gathering. Assessing the caller's response – in the same way that she receipted confirmation of the caller's phone number (line 01) – as "great" (line 08), the receptionist treats the response as information. Repeating "chest infection" the receptionist deletes "or something" marking the diagnostic claim as sufficient for the record.

Below, a third case is presented in which medical information has not been disclosed thus far, and the receptionist asks about the caller's problem at the end of the information gathering activity. Although a different question, the caller's response here is similar to that in extract 5.6. The analysis shows how the caller's orientation to social accountability for their request presents trouble in providing a fitted response.

Extract 5.8 it's in my throat
```
Ashley: 071218

01  REC:    .hh ashley is your phone number two seven
02          zero five four oh one: oh five?
03          (0.3)
04  CAL:    [ye:s  ]
05  REC:    [oh ONE] oh five °sorry° (.) .hh (.) °°↓yeh°°
06          (0.2)
07  REC:    ↑>can you just [give me<] some idea what the=
08  CAL:                   [°yep°   ]
09  REC:    =pro:blem is, please
10  CAL:    #um i 'ave been terribly sick all week and it's .h it's
11          in my throat=but I had um strep throat, (i-/a-) (.) about
12          a month ago: and it's (0.4) #very similar and i'm very
13          #worried that it might be strep again (~)an' i:t's starting to
14          get a lot worse=it's in my chest. (.) .shih #um an' (i'm/um)
15          i can't get out of bed until like .hh uhHhfhh #ih- uh- my pain
16          killers have kicked in [an:#
17  REC:                          [↑ye]a:h that's fine .hh SO
18          i've [>put you on the<]=
19  CAL:        [#ihhh            ]
20  REC:    =LIST< for a nurse to call you so just make sure you keep
21          your phone on oka:y? an' they sh[ould call] fairly soon.
22  CAL:                                    [#ye:ah   ]
```

This case shows another way that receptionists can manage the dilemma of asking about medical information. The receptionist's turn (lines 07-09) is a yes/no interrogative designed to elicit a minimal response from the caller. The turn takes a high entitlement format ("can you") that presupposes that the caller has the knowledge to provide the requested information (Curl & Drew, 2008). Further, asking for "some idea" (line 07) indicates that the preferred format for the information is as a gloss (Jefferson, 1985). Adding to the presupposition that the caller will be able to gloss the information, is the adverbial 'just', which evokes a sense that the response should be brief and orients to minimising the burden the request imposes on the caller.

Although the receptionist solicited a gloss, the caller answers with a narrative format, problem presentation (lines 10-16). With salient turn features that build the narrative of a doctorable problem, the caller orients to their accountability (Halkowski, 2006; Heritage & Robinson, 2006). The presentation begins with "i 'ave been terribly sick all week" (line 10) an extreme case formulation, of the type regularly used to justify a claim (Pomerantz, 1986).

This is further justified by invoking a previously confirmed diagnosis "I had um strep throat, (i-/a-) (.) about a month ago:" (lines 11-12), which frames the present problem as a recurrence (Heritage & Robinson, 2006), providing the evidentiary grounds on which to be reasonably concerned about their current symptoms which are "#very similar" (line 12). This lays the narrative groundwork for the candidate diagnosis of "strep" (line 13). The caller displays troubles resistance "i:t's starting to get a lot worse" demonstrating that they have not sought care at the first sign of a problem but has waited a reasonable amount of time and sought help when only their condition worsened (Heritage & Robinson, 2006).

Furthermore, that the caller is "very #worried" (line 12-13) and unable to "get out of bed" (line 15) demonstrates that the problem is affecting their day to day life and thus doctorable. Finally, the caller not only describes their problem but demonstrates it too, suspending their turn with an expression of emotion (line 15) (Lerner, 2013), and a 'creaky' voice (Hepburn & Bolden, 2012) displaying upset or the vocal effects of an irritated, sore throat. The response is markedly not a gloss – it is a detailed and thorough telling, presenting evidence for the caller's proposed diagnosis of strep throat. The caller treats the receptionist's question as one that brings into question the doctorability of their problem.

Responsive to the receptionist's question enables the caller to present their problem in accordance with their own agenda (Heritage & Robinson, 2006). The caller treats their access to a same-day appointment as contingent on how they answer this question. They prioritise their accountability as a person seeking medical care over fitting their answer to the design of the question. As such, they take the opportunity to demonstrate their legitimate and reasonable need for an urgent appointment.

Like extract 5.7, the receptionist cuts off the caller's talk, (line 17) indicating that the story has provided a sufficient answer. They assess the telling so far as "fine". As the previous three cases have also shown, after receipting the answer the receptionist sums up the next steps (lines 18, 20-21). In an orientation to the caller's demonstration of sickness and urgency, the receptionist reassures them that the nurse should call "fairly soon" (line 21).

Summary

This analysis presented in this chapter showed that receptionists managed the dilemma of how to solicit a health-related disclosure by 1) only asking when callers had not disclosed the problem in their initial request and 2) where they did ask, they treated the question as gathering information. The analysis showed that conditions for a referral were implicitly and explicitly built as having symptoms (extract 5.4) or a medical problem. The chapter also showed that concerns with doctorability arose when callers described their problems. This was particularly evident when callers interpreted the receptionists' requests as calling them to account.

When callers disclosed a medical problem in their request, receptionists immediately moved to grant the request, and their closing summaries explicitly tied the solution they had progressed to the caller's medical problem. When callers did not disclose a medical problem in their request, receptionists routinely solicited medical information at the end of gathering information, and before bringing the call to a close with a summary. In three cases (extracts 5.5, 5.6 and 5.7) the questions were tied to the information gathering activity with an 'and' preface (Heritage & Soronjen, 1994). Some callers responded straightforwardly to this question (extract 5.5, 5.6). For others (extracts 5.7 and 5.8), who interpreted it as a challenge to the legitimacy of their request it caused trouble. These callers demonstrated their legitimate, doctorable sickness (Heritage & Robinson, 2006; Halkowski, 2006). In these cases, the receptionists cut off the caller's talk indicating they had enough information to fulfil the requirements for a referral.

In sum, this chapter shows that receptionists skilfully manage the disclosure and solicitation of medical information that is challenging for both them and callers (Ghallagher et al., 2001; Neuwelt et al., 2016; Sikveland & Stokoe, 2017a; Sikveland et al., 2019) by treating it as part of the routine collection of information in service of a referral to the triage nurse. Having presented the findings, I now turn to a discussion of the research and findings.

Chapter 6: Discussion

There is widespread agreement on the importance medical receptionists have in health care, but there is a lack of consensus about how they do their work with some concern that they are unhelpful. As Mauri Ora and primary health care in New Zealand more generally transition to new ways of delivering health care, the study of how the tasks of medical reception are accomplished in real-life, situated interactions is important. Conducting an examination of calls between medical receptionists and callers using the conversation analytic method, this research aimed to reveal how receptionists at Mauri Ora managed incoming calls. One thread of the analysis examined how requests were made by callers, and how receptionists responded to them. Another line of inquiry examined how receptionists managed requests that were non-grantable. Finally, I considered where and how medical information was disclosed and solicited, and how receptionists responded to it.

The research provides evidence that in phone calls Mauri Ora's receptionists skilfully use interactional practices to facilitate access to = services on offer. The analyses showed how receptionists managed requests to show callers they understood what they were asking for and were doing something to help in a relatively quick and efficient way. When callers requested appointments, receptionists worked within the constraints of availability to shape non-grantable appointment requests into grantable requests. Examining where and how medical information was disclosed or asked for showed another way that receptionists skilfully worked within the constraints of their role. Only asking about medical information when callers did not disclose their problem, receptionists solicited a brief description using interactional practices that characterised the question as routine and for the record. Yet, sometimes callers had trouble making sense of this question, causing trouble in the smooth progression of the interaction. This research has shown that Mauri Ora's receptionists are oriented towards being helpful and supportive in facilitating access to health care, findings that have empirical and theoretical implications and potential applications for practice.

In this chapter, I further discuss the management of appointment requests and the handing of medical information. Throughout these sections I discuss the implications and practical applications of the research. Following this, I re-visit the ethical process for conducting the research, reflect on the process and findings of the research, and consider how the research might be extended in the future.

Managing a limited resource

The availability of appointments is a practical problem for Mauri Ora's receptionists. This was clear in the data, when callers made appointment requests that were not straightforwardly grantable *because* of the limited availability of appointments. Receptionists are the face of Mauri Ora, and students have been disenfranchised and upset by the availability of appointments at Mauri Ora (Phillip & Mathias, 2018; Potter, 2018; Quirke, 2017). However, my analysis shows that receptionists worked skilfully to provide callers with a solution to their appointment requests. No matter what kind of appointment was requested, receptionists progressed access to a solution. Overall, the findings suggest that Mauri Ora receptionists are oriented towards doing what they can to help callers and facilitating access to the services on offer.

The analysis of how appointment requests were progressed by Mauri Ora's receptionists contributes new understanding of how the constraints of limited resource can be managed in telephone calls. Previous literature on telephone mediated service encounters shows that the availability of services is something that can present a practical problem for call-takers (Lee, 2009, 2011; Sikveland & Stokoe, 2017a, 2017b; Sikveland et al., 2019; Sikveland et al., 2016; Stokoe et al., 2016). The availability of appointments represents one constraint on how receptionists were able to grant callers' requests. In the face of similar constraints, service representatives tend to orient towards tempering access – or gate-keeping. Indeed, in emergency calls this is a fundamental part of the job. Medical receptionists have been framed as doing this too (Arber & Sawyer, 1985; Hewitt et al., 2009; Paddison et al., 2015). The ways that receptionists in the current study progressed callers' appointment requests revealed similarities to practices used by airline agents to manage non-grantable requests for flight bookings. In a similar dilemma, callers to Mauri Ora do not always know if or when the appointment/medical care they are requesting will be available. So, their requests were not always designed in ways that afforded straightforward granting. By asking questions that sought confirmation or clarification on what callers were requesting, receptionists shaped requests turn by turn into one that could be granted. In doing so, the receptionists skilfully constructed the parameters (usually in terms of time and clinician) within which the request could be granted.

Although appointments were never readily available, the triaging process allowed receptionists an alternative way to progress requests. In practice, this meant that receptionists

used urgency as a resource to construct the conditions for grantability. Constructing availability on a timeframe continuum from urgent (today) and the next available appointment (one to two weeks) receptionists established the contingencies for accessing medical care. Receptionists also appeared to refine their specifying questions based on the details and knowledge conveyed in callers' requests. Like dispatchers in emergency services, the receptionists used the caller's first turn as a clue to what kind of help (urgent or routine) the caller needed and designed their responsive turns to most efficiently progress that course of action (Larsen, 2013). Likewise, callers collaborated in the shaping of their requests by aligning with the receptionists' specifying questions, something that Lee (2009, 2011) observed to occur when airline booking agents used similar practices. In shaping requests like this, receptionists managed to provide access to some kind of solution – whether booking an appointment or making a referral to the triage nurse – to all callers who sought medical care.

The findings suggest that receptionists make referrals to triage when a legitimate problem is presented, and orient to progressing a helpful solution for the caller in some way. While often unable to book a timely appointment due to their limited availability, the triage process provides another route to medical care. If an appointment request were to be declined, the caller would not have access to any help. If a referral to triage is made, even if the caller's problem is not deemed urgent enough for an appointment, they will still be given advice by the triage nurse. So, the receptionists are offering the solution that is most likely to have a helpful outcome for the caller, presenting further evidence that they are oriented towards facilitating access rather than withholding it.

The findings have important implications for the practice of medical receptionists at Mauri Ora, as well as the overall provision of the service. Stokoe and colleagues (2016; Sikveland et al., 2016) found that non-granting of requests without progressing an alternative solution statistically correlated with patients reporting low helpfulness and satisfaction with their calls. It burdened patients with the job of driving the call forward to a solution. What was more effective was when receptionists offered another option or otherwise carried the call forward. The analysis presented in this research revealed no evidence of non-granting that lead to the kind of patient burden Stokoe and colleagues identified, and clear evidence that receptionists were oriented towards carrying the call forward to a solution. In this way, being helpful is evident as a practical matter accomplished in interaction. This demonstrates how institutional imperatives like providing efficient and quality care (Health Care Home

Collaborative, 2018b) are actually accomplished in practice, and the important role medical receptionists play in achieving the broader goals of delivering primary health care.

Moreover, in showing how receptionists helped patients to access health care, the research demonstrates that far from gate-keeping, Mauri Ora's receptionists work to facilitate access to health care. Examining how help actually happened in calls to Mauri Ora contributes to the discursive respecification of help as a social practice rather than an abstract concept (Wiggins & Potter, 2008). Early psychological theory and empirical findings on helping conceptualised it as being a social process (Latané & Darley, 1970; Moriarty 1975) and something that Sacks' early work examined happening in situ. Crucially, Sacks found that help – and who has the rights and obligations to give and ask for it – is fundamentally organised by social relationships. That is to say, who one person is to another in any given context determines whether they are appropriate givers or seekers of help. In the context of calls to Mauri Ora, receptionists demonstrated an orientation to callers as legitimately and appropriately seeking help, and themselves as responsible for giving help. Their relationship to callers, as representatives of an institution fundamentally concerned with helping people, is implicated in the obligation and responsibility receptionists have to those who call Mauri Ora. Hence, in the current research receptionists helped callers by progressing their interactional projects in ways that avoided burden on the callers and facilitated access to the services on offer. Receptionists' managed the limited availability of appointments in ways that demonstrated orientation towards facilitating access to help rather than hindering it.

Dealing with medical disclosures

Handling health-related information is a dilemma for medical receptionists (Arroll, 2011; Gallagher et al., 2001; Neuwelt et al., 2016), and I analysed where and how medical information was disclosed by callers or solicited by receptionists. Previous research suggests that patients may be reluctant to disclose their health problems (Gallagher et al., 2001; Sikveland & Stokoe, 2017a; Sikveland et al., 2019), and report perceiving receptionists who make medical decisions or handle medical information as acting outside of their remit (Gallagher et al., 2001; Paddison et al., 2015). This is a dilemma for all involved. Without medical training, it is out of receptionists' domain of expertise and entitlement to handle medical information, yet they are often required to do it. This was a particularly noticeable dilemma when receptionists were triaging callers. In triaging patients, Mauri Ora receptionists oriented to the need to get a medical problem (the reason for referral) on the

record, presenting an occasion for examining how they managed health-related information. How they constructed the boundaries of their role regarding medical information showed an orientation to their obligation to patients and practice. In managing this dilemma, the analysis showed that receptionists had some trouble asking about medical information, and although they skilfully used interactional practices to manage this problem some trouble still occurred.

Where and how receptionists solicited problem descriptions showed handling medical information to be troublesome. The most straightforward way that receptionists managed the dilemma was not to ask for a problem description. This occurred in cases were callers disclosed their problem early in the call. Receptionists treated these disclosures as sufficient to fulfil their obligation to record a reason for the triage referral. However, not all callers offered a problem description, and in these cases the receptionists solicited a description. The analysis showed that receptionists asked about medical information in the last possible place – at the end of the series of information gathering questions – and always after urgency had been confirmed. By soliciting a problem description *after* enacting the referral process, receptionists built their questions to display that they were not assessing or challenging the legitimacy of a caller's need for referral. Furthermore, by locating the question at the end of the information gathering sequence, receptionists framed the questions about the caller's problem as the same type of routine question. Turn design features like the 'and-preface'(Heritage & Sorjonen, 1994) or requesting a 'gloss' (Jefferson, 1985) were also used to accomplish this. In doing so, receptionists demonstrated an orientation to the boundaries of their expertise and the rights afforded to them. It is within their remit to gather information that will be used for the record, but not to assess the seriousness or urgency of medical problems.

Accountability for seeking service from an institution is routinely observed in the reasons people give for asking for help (e.g. Halkowski, 2006a; Heritage & Robinson, 2006; M. R. Whalen & Zimmerman, 1987). Like patients in the doctor's office (Heritage & Robinson, 2006), callers to Mauri Ora described their problems in ways that showed an orientation to social accountability for seeking medical care. Just as patients orient to a responsibility to present themselves as having appropriately discovered that their symptoms are just that – symptoms – and not part of the everyday experience of having a body (Halkowski, 2006), callers also oriented to this as relevant concern. This came to the fore when receptionists asked callers about medical information. This caused trouble, when sometimes callers demonstrated difficulty in making sense of why receptionists were asking

them about their problem. Which is to say, caller and receptionist were misaligned on the action implemented by the receptionist's question. While receptionists worked to frame the question as gathering routine information, in some cases callers interpreted the question as a challenge to the doctorability of their request and so treated it as accountable. The concept of doctorability has been used to describe how patients justify seeking medical care (Heritage & Clayman, 2010; Heritage & Robinson, 2006). Callers oriented to these concerns in how they responded to questions about their medical problem. In orientation their access to care being at stake, some callers produced long and detailed narrative accounts of their problem. However, receptionists oriented instead to their own accountability for making a referral to triage. By getting a reason for the triage referral on the record receptionists obtained evidence for why they made a referral that they could briefly relay to the nurse.

These different action orientations lead to misalignment (Jefferson & Lee, 1981). Receptionists demonstrated an orientation towards obtaining just the right about of information to progress the call and accomplish the task of a referral to the triage nurse. When callers produced a detailed account, receptionists cut the narrative short and moved to the next activity indicating that the information provided was sufficient. When callers' responses were more closely aligned with providing a description in the form of information, receptionists progressed the call more smoothly to confirmation and closing. Thus, they constructed the boundaries of their role as a receptionist through their interactional conduct.

The constraints placed on medical receptionists by their limited domain of expertise presents trouble for patients and receptionists alike when receptionists are required to make medical decisions. The evidence presented in the thesis suggests that receptionists managed this dilemma by acting conservatively, treating any description of a medical problem as sufficient to warrant a triage referral. In all cases where an appointment was requested and an out-of-the ordinary problem or symptoms were described the caller was referred to triage. This suggests that rather than deciding whether someone was sufficiently unwell to warrant an urgent appointment, receptionists treated any claim to the experience of a problem made by callers as legitimate. So, in handling health-related information, receptionists also managed their position in the primary health care team and the knowledge and power that affords them. Receptionists deferred to callers' primary epistemic access to their own experiences (Sacks, 1984) and their rights to describe and define their problem as urgent or requiring help. Receptionists did not grant access to the triage system based on what the caller's problem was, they only treated it as required that they had one.

The evidence presented in the research suggests that receptionists began to progress referrals to triage before getting the problem on the record (if it was not offered by the caller), and no matter what kind of problem description callers gave, the referral continued to progress. This suggests that the information solicitated had no impact on the outcome. Although receptionists framed their questions as routine, callers still oriented to the need to present a detailed account of their problem. Given that the receptionists and callers alike oriented to soliciting and disclosing health information as difficult, the findings pose the question of whether and how receptionists should ask about medical information. If the information serves to give the nurse preliminary information and explain why the triage referral was made, perhaps trouble could be pre-empted by explicitly framing the description as something to be briefly relayed to the nurse, to make more transparent to the caller what the institutional relevance of the question is.

Theoretical contributions

The findings of this research contribute to a different way of examining how issues of rights to knowledge, accessibility of services, rights to experience are relevant in how health services are delivered. The conversation analytic approach has been criticised for decontextualizing the social interactions it undertakes to examine (Wetherell, 1998). Yet rather than neglecting to consider the context in which an interaction exists, the approach seeks to prioritise the aspects of it that participants themselves treat as important for accomplishing the action they are engaged with (Schegloff, 1997, 1998). Much like approaches to gender (Kitzinger, 2000; Wetherell, 1998), even though Mauri Ora's receptionists can be understood to be working within the context of a unique student health service I have not considered these factors *a priori* to make sense of or interpret the action participants accomplished in their talk. Yet through leading with the data I have arrived at conclusions which have broader implications for issues of knowledge and power in the role of Mauri Ora's receptionists. My motivation for doing the research has shaped the findings, but I have not started with the assumption that the way receptionists managed calls would be skilful but have undertaken to *show* that and how it is. Moreover, taking the conversation analytic approach has revealed findings that might not otherwise be noticed but are consequential for the unique experience of service users and the work Mauri Ora's receptionists do. The differences between the findings of this research, and that of Sikveland and Stokoe (and Symonds) (Sikveland & Stokoe, 2017a, 2017b; Sikveland et al., 2019; Sikveland et al., 2016; Stokoe et al., 2016) whose analysis drew on interactions between

callers and general practice receptionists in the UK's national health service demonstrate this, with implications for policy and practice that may be informed empirical evidence, and possible applications into the training of Mauri Ora's receptionists.

Bracketing off consideration of aspects of the context an interaction is situated in that are not oriented to by participants means that when issues of knowledge and power come to the fore they are thoroughly grounded in what matters to participants. Doing so enabled me to take a critical perspective on how receptionists' work is situated within the context of Mauri Ora and the institution of medicine, in a way that is grounded in what receptionists doing the work and callers using the service treat as important in those moments.

Ethics revisited

Although the empirical work presented in the thesis draws on a small corpus of data, the data proved to be a rich source of findings. This demonstrates one of the benefits of using naturalistic data (Wiggins & Potter, 2008). Taking this approach however, gave rise to some ethical dilemmas to be negotiated. The process for ethical approval for this study lasted approximately five months and continued through data collection as amendments were sought. In the scope of a Master's degree, this was a significant hinderance to my ability to conduct the research.

The very idea of collecting and transcribing naturalistic health care data was challenged as a risk to the confidentiality and privacy of participants, given that I was a fellow student and colleague. It was suggested that actors be used to recreate interactions with receptionists, and that transcriptionist be hired to transcribe data. While it is of course critical that the identities of participants are protected, the collection of naturalistic data is fundamental and in discursive psychology using conversation analysis. The suggestion that actors could replace real-life callers undermined the theoretical framework the research is built upon and would have been an undue misuse of Mauri Ora's time. Furthermore, to hire a transcriptionist ignores the fact that conversation analytic transcription is a skill that takes many years to master. Moreover, as discussed in the Method chapter, transcription is the first analytic task in conversation analysis. What is more, a commercial transcriptionist would not necessarily have any greater imperative to maintain confidentiality than that denoted by my own integrity as an academic researcher. In my view, these recommendations were outside of the purview of an ethics committee and represented a lack of understanding about qualitative research methodologies.

The process of obtaining consent was also a topic of protracted negotiation. Initially, an information message was proposed that would also direct callers to a publicly available information sheet, including contact details of myself and my supervisors if any person had further questions or concerns. As this recorded message was on and a half minutes long, it was deemed to be a possible barrier to accessing services from Mauri Ora. However, the product of negotiation actually yielded a consent process that was much more time consuming for participants. While recorded calls averaged less than two minutes, phoning participants to discuss information sheets and consent forms took between five and ten minutes. The ill-fitted consent procedure meant that data collection had to be extended from a brief two-week period to intermittent collection over a period of three months. While well intentioned, in practice this resulted in poor use of the time and support kindly given by Mauri Ora. Furthermore, in the process of collecting data and conducting the analysis there was minimal evidence to suggest that the issues that held up approval were valid. For example, when I called participants to discuss their consent forms and the information sheets, students expressed great enthusiasm to participate in work that that could be beneficial to fellow students and the Mauri Ora service. While one caller did opt to withdraw from participating upon my calling them, the ability and opportunity to withdraw could have been possible with a much more fitted and functional consent process.

In light of the significant impact the ethical constraints had on the research, it is worth considering that academic institutions hold great power in the world. Knowledge gained from research is considered to be important and valuable and forms the basis of how other institutions operate – medicine included. However, it must be acknowledged that for the most part, academic research presents one view of the world (positivist and objective) and narrowly defines what counts as scientific knowledge. The extended negotiations and concerns raised by the University Human Ethics Committee regarding this study point to a fundamental misunderstanding of how discursive psychology and conversation analysis is conducted. Ethics committees have a responsibility to understand a range of knowledges and methods and weigh the benefits of conducting research fairly against the protentional risks. The findings of this research show how and why such situated, naturalistic data is valuable and beneficial.

Reflections on the research process and findings

My own knowledge and experience (doing reception work) at Mauri Ora has influenced the thesis and the findings of the research. Familiarity with the procedures and processes for making appointments and providing other services was valuable in interpreting the data and the actions implemented by the talk of the receptionists. However, the benefit of using the conversation analytic method is that the interpretive gap between my analysis and the data itself is small (Edwards, 2012), given that the data is presented in a way that represents it as it occurred in the real world. The findings that the receptionists demonstrated skill in their use of interactional practices is grounded in the real conversations that I examined, yet they also reflect my understanding and knowledge of the role. To do medical reception at a large practice like Mauri Ora requires working knowledge and near constant monitoring of the current availability of doctors' appointments, nurses' appointments, what kind of things each clinician can do, as well as the more fixed administrative processes.

Being a member of the institutional cultural group that the data was collected from meant I was more easily able to access and interpret the experience and skill that was represented in the way the receptionists managed the calls. Moreover, my involvement in reception work has meant that I have experienced the dilemmas that are evident in the data presented in the analyses and the awkwardness of feeling responsible for a lack of available appointments but also wary of overloading my clinical colleagues. Showing how receptionists managed to provide callers' with what they were asking for (or an appropriately helpful alternative) and to have grounded evidence of these skilful practices was a rewarding experience as a researcher.

Future directions

Since collecting the data at Mauri Ora, the way triaging is done has changed. As part of the transition to Health Care Home (Health Care Home Collaborative, 2018b), a GP-triage process has been implemented. This means receptionists now have two options for triaging patients – put callers on the nurses' list, or the GP's. Guidance from the practice suggests that receptionists should use their judgment and experience to decide what problems are suitable for referral to GP-triage. This more explicitly involves receptionists in assessing the nature of a caller's problem, and thus they may need to gather more detailed information. This presents an invaluable opportunity to examine how the changes are implemented in practice, and how that compares to the present findings. Another way that the scope of the research could be

furthered is to follow callers through to the phone call they have with the triage nurse. With nurses either offering advice or a same-day appointment, the practices and processes by which either action is accomplished presents an interesting parallel with the present research. Examining these interactions would provide valuable insight into how nurses communicate, their role in the primary care team and triaging as a system, building on the findings of this research and the prior literature (e.g. Gallagher, Huddart, & Henderson, 1998; Murdoch et al., 2014).

Finally, conversation analysis is increasingly moving towards the study of videoed co-present interactions, which can capture the full array of conduct that people engage in. Analysing video recordings of face to face interactions with receptionists would present an opportunity to answer questions with greater richness. Although Hewitt and colleagues (2009) and Gallagher and colleagues (2001) studied face-to-face encounters, to my knowledge a multimodal analysis of the interaction has not been done. Mauri Ora also provides also counselling services which people tend to access face-to-face. Examining how these interactions unfold could present invaluable understandings of how receptionists manage a resource that is even more limited that health appointments and sensitive disclosures related to mental health. Moreover, when engaging with patients on the phone receptionists are situated within a physical environment and also using their computers. Capturing these activities for examination would enable a more nuanced and clear understanding of what receptionists are doing and how the ways they work to accomplish the interactional project are shaped by and shape their engagement with the patient management software, their physical environment and telephones.

Concluding comments

Medical receptionists contribute to the delivery of good health care. A first point of contact in the health care system, they have the important job of determining who, when and how people get access to what they need from their health care provider. In a context where students have expressed concern about their wellbeing and frustration with the accessibility of care (Phillip & Mathias, 2018; Potter, 2018; Quirke, 2017), the receptionists' role in the transformation of callers from people to patients (Neuwelt et al., 2015) cannot be underestimated. The findings suggest Mauri Ora's receptionists are oriented towards progressing smooth, supportive interactions has implications for the conceptualisation of their role as the caring face of an important service. Maintaining the balance between

professionally accomplishing the task at hand and supporting callers to access what they need suggests that the receptionists might be acting compassionately towards students and considering their unique situations and needs.

For the most part though, general practice receptionists have been overlooked in health literature and at the structural level of practice. The findings of this research also contribute to the conceptualisation of helping as a social practice, that is organised and observable in interaction. Medical receptionists and patients skilfully used interactional resources to accomplish social actions, which in this thesis can be broadly conceptualised as seeking and giving help. Receptionists also oriented to and managed their role within the primary health care team and as it related to callers. This demonstrated consideration of patients' needs and their rights and abilities to competently determine their health needs, constructing the receptionist's role as a facilitator of access rather than withholding it.

The main contribution of the thesis is the finding that receptionists do not necessarily act as gate-keepers in the sense of withholding access to care, but rather work to facilitate and grant access to care as best as they are able to. They are skilled and supportive in providing access to health care in a smooth and efficient manner. This finding destabilises the notion that receptionists are impersonal and unhelpful and shows the existing literature to be insufficiently representative of the care and helpfulness receptionists can demonstrate in their work. My work contributes evidence that Mauri Ora's receptionists are indeed concerned with the needs of callers and are skilled in helping them to access care. This has implications for how receptionists are conceptualised in literature, but also how their role is considered in practice and policy. At a practical level, this finding can make a difference for how receptionists are perceived in their day to day work, the experience of patients interacting with them, and the position they occupy in the health care system.

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Appendices

Appendix A

Transcription key

The transcription symbols used in this thesis to represent the vocal conduct of participants are those designed by Gail Jefferson that are used within conversation analysis. Below are adapted descriptions from the work of Jefferson (2004) and Hepburn and Bolden (2017).

Sequential and temporal relationships

[word]	Square bracket indicates talk of two or more speakers occurring simultaneously (overlapping). The left bracket indicates the onset of overlapping talk, and the right bracket indicates the end of overlapping talk.
word= =word	An equal sign indicates that talk is latched with no intervening silence between turns or within a turn
(.)	A period in parentheses indicates a silence of less than two tenths of a second
(0.0)	Numbers in parentheses indicate silence in seconds

Speech delivery

word.	A period marks falling intonation at the end of a unit of talk
word,	A comma marks slightly rising, continuing intonation at the end of a unit of talk

word?	A question mark marks rising intonation at the end of a unit of talk
<u>wo</u>rd	Underling indicates that the underlined sounds are stressed or emphasised.
WORD	Uppercase letters indicate talk that is loud relative to surrounding talk
˚word˚	Degrees signs indicate talk that is quieter or soften than surrounding talk.
˚˚word˚˚	Double degrees signs indicate particularly quiet or whispered talk.
wo<u>:</u>rd	A word/utterance component followed by an underlined colon indicates that the pitch moves up then down in the production of the word
w<u>o</u>:rd	A word/utterance component underlined and followed colon indicates that the pitch moves down then up in the production of the word
↑word	An upwards arrow indicates sharply rising pitch
word↓	An upwards arrow indicates sharply lowered pitch
>word<	Inwards pointing arrows indicate talk that is sped up or compressed
<word>	Outwards pointing arrows indicate talk that slow or drawn out
<word	A single outward pointing arrow at the beginning of an utterance indicates talk that is 'jump-started'
word:	A colon indicates that the preceding sound is stretched or elongated
word-	A hyphen indicates that the preceding sound is cut-off
#word	A hash mark indicates 'creaky voice'
~word	A tilde indicates 'wobbly voice'
.hh hh	'h' indicates breathiness, with the number of 'h's' indicating the length of the breath. Breathiness is also used to represent laughter.
wo(hh)rd	Indicates breathiness within a word
.snih .shih	Indicates sniffing

Transcriber's notes

( )	Brackets containing no text indicate talk that is inaudible so cannot be transcribed
(word)	Talk encased within single brackets indicates uncertain hearing
((word))	Talk encased within two brackets indicates transcriber's comments

Appendix B

Script for pre-recorded information message

If your call is urgent or to skip this message at any time, please press 0. Otherwise please be aware that your call may be recorded for research purposes. If you agree to this, please press 1 and note that by selecting this option the researcher will contact you soon on the phone number you give to confirm your consent to your call being kept. You can ask the recording to stop at any time. If you do not agree to your call being recorded for research purposes, then please press 2 now. Thank you

Appendix C

TE WHARE WĀNANGA O TE ŪPOKO O TE IKA A MĀUI
VICTORIA
UNIVERSITY OF WELLINGTON

INVESTIGATING TELEPHONE CALLS TO A STUDENT HEALTH AND COUNSELLING SERVICE

ORGANISATIONAL INFORMATION SHEET FOR MAURI ORA

Application ID: 0000026843

Your organisation is invited to take part in this research. Please read this information before deciding whether or not you would like to take part. If you decide to participate, thank you. If you do not decide to participate, thank you for considering this request.

Who am I?

My name is Fiona Grattan and I am a Master's student in the School Psychology at Victoria University of Wellington. This research project is work towards my thesis.

What is the aim of the project?

Recently, Victoria University of Wellington has undertaken a commitment to be a health promoting university, and as such research that presents an opportunity to broaden and deepen understanding of student health and wellbeing is highly relevant. This project will use conversation analysis to investigate telephone calls to Mauri Ora, in an effort to shed light on student's first contact with the service, and the provision of the service in telephone calls. The focus of the research will be on the communication between staff and students, and observing patterns across interactions.

Conversation analysis uses detailed analysis of social interactions that occur naturally to understand and make observations on how talk is used to achieve social action, how it is structured, and how it is that we understand each other in conversation. Through this process of analysis, this research may offer insight into students' initial communication with Mauri Ora's service that may otherwise not be available, with possible implications and applications for service improvement (although the research does not aim to evaluate individuals or current practice).

This research builds on the work of conversation analyst Elizabeth Stokoe at Loughborough University in the United Kingdom, who has carried out similar research on calls to general practices, as well as a wider body of conversation analytic research on social interactions in health care settings**.**

How can you help?

If your organisation agrees to take part, recordings of calls on the Mauri Ora Student Health and Counselling phone line will be recorded for use as data.

Upon consenting to participate, if there are any call recordings which participating staff members do not wish to be included as data, they are asked to notify the researcher within five working days of making the recording to have data withdrawn from the study.

Upon agreeing to take part, the use of the Mauri Ora phone line and website to disseminate information about the research taking place is requested.

Privacy and Confidentiality

The privacy and confidentiality of Mauri Ora's staff and service users will be of utmost importance to the research and researchers.

The data provided will not be accessed by Mauri Ora nor used by Mauri Ora in any way to assess or evaluate job performance, nor will the research assess or evaluate job performance.

Staff will be offered to opportunity to meet with the researchers prior to data collection, at which time they may raise questions or concerns, will be given written information sheets, and asked to sign a consent form if they would like to participate.

Your data will be securely stored for a period of 10 years at Victoria University of Wellington.

The recordings will be transcribed (turned into text) providing a written representation of the interaction. This will be done primarily by Fiona, and may also be done by the Supervisors, or Ethyn Sturm who is a member of the research team. Any identifying information (e.g. names, dates, places) will be omitted or changed, and names will be replaced with a pseudonym so staff are not identifiable. Typically, short extracts of these transcripts will be used in the thesis and/or scholarly publications. In reports and publications, staff who have participated will be referred to as "call-taker" rather than a pseudonym to prevent any recognition on the basis of gender or the syllables of the pseudonym.

The audio recordings will also be digitally edited to remove identifying information such as names, dates and contact information. Using audio editing software, this information will be scrambled so that it is inaudible.

Short extracts of no more than one minute from the recordings with all identifying information removed may be played at one-off international professional or academic seminars/workshops/conferences. The pitch will be changed electronically to make identification of the speakers highly unlikely. The researchers who listen to or view your data are not interested in individuals but observing patterns across different interactions. In conferences or presentations, we may also give researchers a copy of excerpts from the anonymised transcripts. Researchers attending these conferences will not be permitted to make audio recordings of any data played.

Short extracts from the recordings with all identifying information removed may be played at data sessions with other researchers in the Discursive Psychology (VUW, School of Psychology) and Wellington Interaction Data Analysis (UoO, School of Medicine & Health Science) teams as part of the

analytic strategy of conversation analysis. Mauri Ora as an organisation will be identified as the service from which data were collected.

If you accept this invitation, what are your rights the rights of your staff as research participants?

Your staff do not have to accept this invitation if they don't want to. If your staff do decide to participate, they have the right to:

•   ask for the recorder to be turned off at any time during the phone call;

•   withdraw any or all of their data from the study for any reason by the end of day on 30th November 2018;

•   ask any questions about the study at any time;

•   access a lay summary of the research findings.

A summary of findings will be emailed to participants, available at:
https://discursivepsychology.wordpress.com/ and may be made available on the Mauri Ora website.

What will the project produce?

The information from the research will be used in a thesis as part of the requirements for a Master of Science degree. Findings from the data you provide may be included in publications to scientific journals, presentations at academic conferences, or other academic reports.

Our philosophy/kaupapa is to engage in "research for and with" rather than "research on" participants. We therefore aim to maintain a respectful, constructive "appreciative inquiry" (strengths-based) approach to analysis and in any publications or presentations arising (i.e. providing neutral description, constructive critique, inviting dialogue and critical peer reflection, etc.).

If you have any questions, either now or in the future, please feel free to contact either Fiona Grattan, Ann Weatherall, or Antonia Lyons as listed overleaf.

Fiona Grattan	**Dr Ann Weatherall**	**Dr Antonia Lyons**
Master's Student	Professor of Psychology	Professor of Health Psychology
School of Psychology	Victoria University of Wellington	
Victoria University of Wellington		Victoria University of Wellington
	Ann.weatherall@vuw.ac.nz	
		Antonia.lyons@vuw.ac.nz
Fiona.grattan@vuw.ac.nz	04 4635211	
		04 463 4758

Human Ethics Committee information

If you have any concerns about the ethical conduct of the research, you may contact the Victoria University of Wellington HEC Convener: Dr Judith Loveridge. Email hec@vuw.ac.nz or telephone +64-4-463 6028

Appendix D

TE WHARE WĀNANGA O TE ŪPOKO O TE IKA A MĀUI

VICTORIA
UNIVERSITY OF WELLINGTON

Investigating Telephone Calls to a Student Health and Counselling Service

CONSENT FOR ORGANISATION TO PARTICIPATE IN RESEARCH

Application ID: 0000026843

A digitised copy of this consent form will be held indefinitely.

Researcher: *Fiona Grattan, School of Psychology* Victoria University of Wellington*.*

• I have read the Organisational Information Sheet and the project has been explained to me. My questions have been answered to my satisfaction. I understand that I can ask further questions at any time.

• I understand that staff members of the organisation I represent will be asked to have their phone calls recorded in their capacity as Administrators and Receptionists at Mauri Ora Student Health and Counselling during the data collection period to be used as data for the research project.

I understand that:

• Mauri Ora and its staff are under no obligation to participate.
• The data staff and service users provide will not be accessible to Mauri Ora nor be used to evaluate or assess staff's job performance in any way nor will the research assess or evaluate job performance.
• Staff are free to withdraw from this study for any reason. Staff may choose which recordings to have included in the data, and can ask to have recordings excluded from the data within five working days from making the recording. Any data staff ask to have excluded will be destroyed.

- De-identified call recordings and transcripts will be securely stored for a period of 10 years at Victoria University of Wellington.

- I understand that the data will be used for a Master's thesis and/or academic publications and/or presented to conferences and/or in other academic reports.

- Short extracts from the recordings with all identifying information removed may be played at one-off international professional or academic seminars/workshops/conferences. The pitch will be changed electronically to make identification of the speakers highly unlikely.

- Short extracts from the recordings with all identifying information removed may be played at data sessions with other researchers in the Discursive Psychology (VUW, School of Psychology) and Wellington Interaction Data Analysis (UoO, School of Medicine & Health Science) teams as part of the analytic strategy of conversation analysis. The pitch will be changed electronically to make identification of the speakers highly unlikely. These researchers will sign confidentiality agreements before any data is presented to them.

- The names of staff and callers will not be used in reports, publications, or presentations, nor will any identifying information.

- Mauri Ora as an organisation will be identified as the service from which data from collected.

- A summary of findings will be emailed to participants, available at: https://discursivepsychology.wordpress.com/ and may be made available on the Mauri Ora website.

Signature of organisational representative: _____

Name of organisational representative: _____

Date: _____

Appendix E

INVESTIGATING TELEPHONE CALLS TO A STUDENT HEALTH AND COUNSELLING

SERVICE

INFORMATION SHEET FOR MAURI ORA STAFF

Application ID: 0000026843

You are invited to take part in this research. Please read this information before deciding whether or not you would like to take part. If you decide to participate, thank you. If you do not decide to participate, thank you for considering this request.

Who am I?

My name is Fiona Grattan and I am a Master's student in the School Psychology at Victoria University of Wellington. This research project is work towards my thesis.

What is the aim of the project?

Recently, Victoria University of Wellington has undertaken a commitment to be a health promoting university, and as such research that presents an opportunity to broaden and deepen understanding of student health and wellbeing is highly relevant. This project will use conversation analysis to investigate telephone calls to Mauri Ora, in an effort to shed light on student's first contact with the service, and the provision of the service in telephone calls. The focus of the research will be on the communication between staff and students, and observing patterns across interactions.

Conversation analysis uses detailed analysis of social interactions that occur naturally to understand and make observations on how talk is used to achieve social action, how it is structured, and how it is that we understand each other in conversation. Through this process of analysis, this research may offer insight into students' initial communication with Mauri Ora's service that may otherwise not be available, with possible implications and applications for service improvement (although the research does not aim to evaluate individuals or current practice).

This research builds on the work of conversation analyst Elizabeth Stokoe at Loughborough University in the United Kingdom, who has carried out similar research on calls to general practices, as well as a wider body of conversation analytic research on social interactions in health care settings**.**

How can you help?

If you agree to take part, recordings of your calls on the Mauri Ora Student Health and Counselling phone line will be collected as data.

Upon consenting to participate, if there are any call recordings which you do not wish to be included as data, please notify the researcher within five working days of making recording to have data withdrawn from the study.

Privacy and Confidentiality

The data you provide will not be used by Mauri Ora in any way to assess or evaluate your job performance, nor will the research assess or evaluate your job performance.

Your data will be securely stored for a period of 10 years at Victoria University of Wellington.

The recordings will be transcribed (turned into text) providing a written representation of the interaction. This will be done primarily by Fiona, and may also be done by the Supervisors, or Ethyn Sturm who is a member of the research team. Any identifying information (e.g. names, dates, places) will be omitted or changed, and your name will be replaced with a pseudonym so you are not identifiable. Typically, short extracts of these transcripts will be used in the thesis and/or scholarly publications. In reports and publications staff who have participated will be referred to as "call-taker" rather than a pseudonym to prevent any recognition on the basis of gender or the syllables of the pseudonym.

The audio recordings will also be digitally edited to remove identifying information such as names, dates and contact information. Using audio editing software, this information will be scrambled so that it is inaudible.

Short extracts of no more than one minute from the recordings with all identifying information removed may be played at one-off international professional or academic seminars/workshops. The pitch will be changed electronically to make identification of the speakers highly unlikely. The researchers who listen to or view your data are not interested in individuals, but observing patterns across different interactions. In conferences or presentations, we may also give researchers a copy of excerpts from the anonymised transcripts. Researchers attending these conferences will not be permitted to make audio recordings of any data played.

Such short extracts of no more than one minute may also be used in data sessions with other researchers in the Discursive Psychology (Victoria University of Wellington, School of Psychology) and Wellington Interaction Data Analysis (University of Otago, School of Medicine Health Science) teams

as part of the analytic strategy of conversation analysis. These researchers will sign confidentiality agreements before any data is presented to them. Mauri Ora as an organisation will be identified as the service from which data from collected.

If you accept this invitation, what are your rights as a research participant?

You do not have to accept this invitation if you don't want to. If you do decide to participate, you have the right to:

- ask for the recorder to be turned off at any time during a phone call;

- withdraw any or all of your data from the study for any reason within the timeframe outlined

- ask any questions about the study at any time;

- access a lay summary of the research findings.

A summary of findings will be emailed to participants, available at: https://discursivepsychology.wordpress.com/ and may be made available on the Mauri Ora website.

What will the project produce?

The information from the research will be used in a thesis as part of the requirements for a Master of Science degree. Findings from the data you provide may be included in publications to scientific journals, presentations at academic conferences, or other academic reports.

Our philosophy/kaupapa is to engage in "research for and with" rather than "research on" participants. We therefore aim to maintain a respectful, constructive "appreciative inquiry" (strengths-based) approach to analysis and in any publications or presentations arising (i.e. providing neutral description, constructive critique, inviting dialogue and critical peer reflection, etc.).

If you have any questions, either now or in the future, please feel free to contact either Fiona Grattan, Ann Weatherall, or Antonia Lyons as listed below.

Fiona Grattan	**Dr Ann Weatherall**	**Dr Antonia Lyons**
Master's Student	Professor of Psychology	Professor of Health Psychology
School of Psychology	Victoria University of Wellington	Victoria University of Wellington
Victoria University of Wellington		Antonia.lyons@vuw.ac.nz
	Ann.weatherall@vuw.ac.nz	
Fiona.grattan@vuw.ac.nz	04 463 5211	04 463 4758

Human Ethics Committee information

If you have any concerns about the ethical conduct of the research, you may contact the Victoria University of Wellington HEC Convener: Dr Judith Loveridge. Email hec@vuw.ac.nz or telephone +64-4-463 6028

Appendix F

Investigating Telephone Calls to a Student Health and Counselling Service

CONSENT TO PARTICIPATE IN RESEARCH: Mauri Ora Staff

Application ID: 0000026843

A digitised copy of this consent form will be held indefinitely.

Researcher: *Fiona Grattan, School of Psychology* Victoria University of Wellington*.*

- I have read the Information Sheet and the project has been explained to me. My questions have been answered to my satisfaction. I understand that I can ask further questions at any time.

- I agree to have my phone calls recorded in my capacity as an Administrator and Receptionist at Mauri Ora Student Health and Counselling to be used as data for the research project

I understand that:
- I am under no obligation to participate.
- The data I provide will not be used to evaluate or assess my job performance in any way.
- I am free to withdraw from this study for any reason. I may choose which recordings to have included in the data, and can ask to have recordings excluded from the data within five working days from making the recording. Any data I ask to have excluded will be deleted.
- De-identified call recordings and transcripts will be securely stored for a period of 10 years at Victoria University of Wellington.
- I understand that the data will be used for a Master's thesis and/or academic publications and/or presented to conferences and/or in other academic reports.
- Short extracts from the recordings with all identifying information removed may be played at one-off international professional or academic seminars/workshops/conferences. The pitch will be changed electronically to make identification of the speakers highly unlikely.

- Short extracts from the recordings with all identifying information removed may be played at data sessions with other researchers in the Discursive Psychology (VUW, School of Psychology) and Wellington Interaction Data Analysis (UoO, School of Medicine & Health Science) teams as part of the analytic strategy of conversation analysis. The pitch will be changed electronically to make identification of the speakers highly unlikely. These researchers will sign confidentiality agreements before any data is presented to them.
- My name will not be used in reports, nor will any information that would identify me.
- Mauri Ora as an organisation will be identified as the service from which data was collected.
- A summary of findings will be emailed to participants, available at: https://discursivepsychology.wordpress.com/ and may be made available on the Mauri Ora website.

I have provided my email address here so that I may be sent a copy of this consent form, the information sheet and a summary of findings upon completion of the project only.

Email address: _____

Please cross out the options that do not apply:

- I am happy/not happy to be contacted about the possibility of my data to be used in similar research in the future. I give consent/do not give consent for my email address to be used for this additional purpose.

Signature of participant: _____

Name of participant: _____

Date: _____

Appendix G

INVESTIGATING TELEPHONE CALLS TO A STUDENT HEALTH AND COUNSELLING SERVICE

INFORMATION SHEET FOR CALLER PARTICIPANTS

Application ID: 0000026843

You are invited to take part in this research. Please consider this information before deciding whether or not you would like to take part. If you decide to participate, thank you. If you do not decide to participate, thank you for considering this request.

Who am I?

My name is Fiona Grattan and I am a Master's student in the School Psychology at Victoria University of Wellington. This research project is work towards my thesis.

What is the aim of the project?

Recently, Victoria University of Wellington has undertaken a commitment to be a health promoting university, and as such research that presents an opportunity to broaden and deepen understanding of student health and wellbeing is highly relevant. This project will use conversation analysis to investigate telephone calls to Mauri Ora, in an effort to shed light on student's first contact with the service, and the provision of the service in telephone calls. The focus of the research will be on the communication between staff and students, and observing patterns across interactions.

Conversation analysis uses detailed analysis of social interactions that occur naturally to understand and make observations on how talk is used to achieve social action, how it is structured, and how it is that we understand each other in conversation. Through this process of analysis, this research may offer insight into students' initial communications with Mauri Ora's service that may otherwise not be available, with possible implications and applications for service improvement (although the research does not aim to evaluate individuals or current practice).

This research builds on the work of conversation analyst Elizabeth Stokoe at Loughborough University in the United Kingdom, who has carried out similar research on calls to general practices, as well as a wider body of conversation analytic research on social interactions in health care settings.

How can you help?

If you agree to take part, recordings of your call to the Mauri Ora Student Health and Counselling phone line will be collected as data.

Upon consenting to participate, if there are any call recordings which you do not wish to be included as data, please notify the researcher within five working days of giving consent to have your data withdrawn from the study.

Privacy and Confidentiality

Your data will be securely stored for a period of 10 years at Victoria University of Wellington.

The recordings will be transcribed (turned into text) providing a written representation of the interaction. This will be done primarily by Fiona, and may also be done by the Supervisors, or Ethyn Sturm who is a member of the research team. Any identifying information (e.g. names, dates, places) will be omitted or changed, and your name will be replaced with a pseudonym so you are not identifiable. Typically, short extracts of these transcripts will be used in the thesis and/or scholarly publications.

The audio recordings will also be digitally edited to remove identifying information such as names, dates and contact information. Using audio editing software, this information will be scrambled so that it is inaudible.

Short extracts of no more than one minute from the recordings with all identifying information removed may be played at one-off international professional or academic seminars/workshops/conferences. The pitch will be changed electronically to make identification of the speakers highly unlikely. The researchers who listen to or view your data are not interested in individuals, but observing patterns across different interactions. In conferences or presentations, we may also give researchers a copy of excerpts from the anonymised transcripts. Researchers attending these conferences will not be permitted to make audio recordings of any data played.

Such short extracts of no more than one minute may also be used in data sessions with other researchers in the Discursive Psychology (Victoria University of Wellington, School of Psychology) and Wellington Interaction Data Analysis (University of Otago, School of Medicine & Health Science) teams as part of the analytic strategy of conversation analysis. These researchers will sign confidentiality agreements before any data is presented to them.

Mauri Ora as an organisation will be identified as the service from which data from collected.

If you accept this invitation, what are your rights as a research participant?

You do not have to accept this invitation if you don't want to. If you do decide to participate, you have the right to:

• ask for the recorder to be turned off at any time during the phone call;

• withdraw any or all of your data from the study for any reason within the timeframe outlined

• ask any questions about the study at any time;

• access a lay summary of the key findings of the research.

A summary of findings will be emailed to participants, available at: https://discursivepsychology.wordpress.com/ and may be made available on the Mauri Ora website.

What will the project produce?

The information from the research will be used in a thesis as part of the requirements for a Master of Science degree. Findings from the data you provide may be included in publications to scientific journals, presentations at academic conferences, or other academic reports.

Our philosophy/kaupapa is to engage in "research for and with" rather than "research on" participants. We therefore aim to maintain a respectful, constructive "appreciative inquiry" (strengths-based) approach to analysis and in any publications or presentations arising (i.e. providing neutral description, constructive critique, inviting dialogue and critical peer reflection, etc.).

If you have any questions, either now or in the future, please feel free to contact either Fiona Grattan, Ann Weatherall, or Antonia Lyons as listed below.

Fiona Grattan	**Dr Ann Weatherall**	**Dr Antonia Lyons**
Master's Student	Professor of Psychology	Professor of Health Psychology
School of Psychology	Victoria University of Wellington	Victoria University of Wellington
Victoria University of Wellington	Ann.weatherall@vuw.ac.nz	Antonia.lyons@vuw.ac.nz
Fiona.grattan@vuw.ac.nz	04 463 5211	04 463 4758

Human Ethics Committee information

If you have any concerns about the ethical conduct of the research, you may contact the Victoria University of Wellington HEC Convener: Dr Judith Loveridge. Email hec@vuw.ac.nz or telephone +64-4-463 6028

Appendix H

TE WHARE WĀNANGA O TE ŪPOKO O TE IKA A MĀUI
VICTORIA
UNIVERSITY OF WELLINGTON

Investigating Telephone Calls to a Student Health and Counselling Service

CONSENT TO PARTICIPATE IN RESEARCH: Callers

Application ID: 0000026843

A digital copy of this consent form will be held indefinitely.

Researcher: *Fiona Grattan, School of Psychology* Victoria University of Wellington*.*

- The Information Sheet and the project has been explained to me. My ☐
  questions have been answered to my satisfaction. I understand that I can
  ask further questions at any time.
- I agree to have my call recording to the Mauri Ora Student Health and ☐
  Counselling phone line to be used as data for the research project
- A copy of this form that has been completed on my behalf by the primary ☐
  investigator Fiona Grattan in verbal communication with me, along with
  an information sheet will be emailed to me for my records.

I understand that:

- I am under no obligation to participate. ☐
- I am free to withdraw from this study for any reason. I can ask to have ☐
  recordings excluded from the data within five working days from giving
  consent to participate. Any data I ask to have excluded will be deleted.
- De-identified call recordings and transcripts will be securely stored for a ☐
  period of 10 years at Victoria University of Wellington.
- I understand that the data will be used for a Master's thesis and/or ☐
  academic publications and/or presented to conferences and/or in other
  academic reports.

- Short extracts from the recordings with all identifying information □ removed may be played at one-off international professional or academic seminars/workshops/conferences. The pitch will be changed electronically to make identification of the speakers highly unlikely.

- Short extracts from the recordings with all identifying information □ removed may be played at data sessions with other researchers in the Discursive Psychology (VUW, School of Psychology) and Wellington Interaction Data Analysis (UoO, School of Medicine & Health Science) teams as part of the analytic strategy of conversation analysis. The pitch will be changed electronically to make identification of the speakers highly unlikely. These researchers will sign confidentiality agreements before any data is presented to them.

- My name will not be used in reports, nor will any information that would □ identify me.

- Mauri Ora as an organisation will be identified as the service from which □ data from collected.

- A summary of findings will be emailed to participants, available at: □ https://discursivepsychology.wordpress.com/ and may be made available on the Mauri Ora website.

I have provided my email address here so that I may be sent a copy of this consent form, the information sheet and a summary of findings upon completion of the project only.

Email address: Click or tap here to enter text.

- I am Choose an item. to be contacted about the possibility of my data to be used in similar research in the future. I Choose an item. for my email address to be used for this additional purpose.

This consent form has been discussed and the participant has indicated their understanding of each point thereby giving informed consent to participate in the study:

Yes □   No □

Name of participant: Click or tap here to enter text.

Date: Click or tap here to enter text.

Time: Click or tap here to enter text.

Appendix I

Corpus of Telephone Calls to Mauri Ora Student Health and Counselling Service

Confidentiality Form and Protocol for the Use of the Corpus

I understand that this confidentiality agreement applies to the corpus of audio recordings and transcripts from the Mauri Ora Student Health and Counselling Service, that I have been granted access to.

I agree to keep all information confidential and to securely store and transmit any digital or paper files in my possession, in accordance with the following:

• The approval given by the Victoria University of Wellington Human Ethics Committee, and

• The protocols outlined in this document

Data access and management protocol

Access to the corpus of telephone calls can only be given by Professors Antonia Lyons and Ann Weatherall who supervised the original collection of the data. Access will only be granted to bona-fide researchers conducting investigations that aim to broaden and deepen understanding of health and wellbeing by the study of telephone mediated social interaction in relevant settings.

The following "conditions of use" protocol will be strictly adhered to:

• Professors Antonia Lyons and Ann Weatherall must sign off on any publication or other output that arises from studies of the corpus.

• Copies of any publications or other research outputs are to be lodged with Professors Antonia Lyons and Ann Weatherall, who will make them available on a research website where participants can check on the results of the research.

•	Professors Antonia Lyons and Ann Weatherall should be notified about any media releases related to such research or publications.

•	To store, transport and access the corpus data using encrypted or password protected device. Additional copies will not be made or stored elsewhere, or provided to other researchers.

•	That in publications and public presentations, anonymised data excerpts only are to be used.

Professors Antonia Lyons and Ann Weatherall supervise research that records naturalistic social interactions. The overall aim of this protocol is to achieve a balances between (1) making the best possible use of this valuable resource in the interests of ongoing research and (2) meeting the ethical and other obligations to the parties who have been recorded and have contributed to the Corpus.

Professors Antonia Lyons and Ann Weatherall take a conservative approach to data security and access in general and to the audio recordings in particular, for the following reasons:

(i) Participants have consented to the permanent archiving of their recordings on the basis that the Corpus is not an open access dataset because some recordings are of a highly personal nature.

(ii) Audio data of real telephone interactions are not as readily de-identifiable (unlike transcripts which are routinely anonymised), and with advances in information technology now making it easy to move and copy large digital files, stringent processes are required to ensure confidentiality and prevent accidental "escape" of the data. Quite aside from an obligation to abide by the conditions under which informed consent was obtained, such a breach would also be potentially disastrous for the good name of the University and our relationship with the people who have contributed the data.

The protocol for managing access to and dissemination of the Corpus is as follows:

1. Access to data

Access to the Corpus data from outside the data access management protocols is restricted to Professors Antonia Lyons and Ann Weatherall and their students or to researchers authorised by Professors Antonia Lyons and Ann Weatherall.

Everyone who does access the data (researchers) are required to sign and abide by this confidentiality agreement, and to follow these agreed data-handling protocols.

2. Data handling

All researchers are expected to abide strictly by the data access and management protocol, and to ensure the confidentiality and security of the data at all times.

3. Presentation and publication of data excerpts

In settings such as one-off international professional or academic seminars/workshops/conferences excerpts of audio clips, with identifying information removed can be played provided the pitch has been schanged to make identification of the speakers highly unlikely. Additionally, people involved should be briefed on the ethical/confidentiality constraints for that data.

In publications and public presentations, anonymised data excerpts only are to be used.

Any proposed variation on the above practices must be discussed Professors Antonia Lyons and Ann Weatherall and will be agreed on a case-by-case basis, where there is virtually no chance of any party in the recording being identified.

4. Dissemination of research findings and data analyses

Our philosophy/kaupapa is to engage in "research for and with" rather than "research on" participants. We therefore aim to maintain a respectful, constructive "appreciative inquiry" (strengths-based) approach to analysis and in any publications or presentations arising (i.e. providing neutral description, constructive critique, inviting dialogue and critical peer reflection, etc.). For this reason, Professors Antonia Lyons and Ann Weatherall reserve the right to review and exercise sign off on any publications/conference presentations or other outputs based on the Corpus.

Name: ……………………………………………

Signature: …………………………………………

Date: ………………………………………………